Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Enbrel

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a reauthorization request?

☐ Yes - Go to 2 ☐ No - Go to 3

Q2. Is there confirmation of continued positive clinical response since starting Enbel?

☐ Yes ☐ No

Q3. Does the patient have the diagnosis of rheumatoid arthritis?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is there documentation of inadequate response, intolerance or contraindication to at least one or more disease modifying antirheumatic drugs (DMARDs) (e.g., for RA: azathioprine, hydroxychloroquine, D-penicillamine, sulfasalazine, methotrexate and for PsA: leflunomide, methotrexate)?
If YES, go to 17.

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q6. Does the patient have the diagnosis of plaque psoriasis? If No, go to 11.	
☐ Yes	☐ No
Q7. Is the patient 4 years of age or older?	
☐ Yes	☐ No
Q8. Is the disease moderate to severe?	
☐ Yes	☐ No
Q9. Is there documentation of inadequate response, intolerance or contraindication to methotrexate OR ultraviolet-B (UVB) therapy (alone or in combination with other medications) OR acitretin? If Yes, go to 19.	
☐ Yes	☐ No
Q10. Does the patient have limited (plaque psoriasis) disease?	
☐ Yes	☐ No
Q11. Is there documentation of inadequate response, intolerance or contraindication to one topical steroid (high to very high potency) AND calcipotriene 0.005% cream? If Yes, go to 19.	
☐ Yes	☐ No
Q12. Does the patient have a diagnosis of polyarticular juvenile idiopathic arthritis (pJIA) Juvenile psoriatic arthritis (JPsA), or Psoriatic arthritis (PsA)? If YES, go to 13. If NO, go to 15.	
☐ Yes	☐ No
Q13. Is the patient 2 years of age or older?	
☐ Yes	☐ No

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Patient Name:	**Prescriber Name:**

Q14. Is there documentation of inadequate response, intolerance or contraindication to one disease modifying anti-rheumatic drug (DMARD) (e.g., sulfasalazine, methotrexate)? If Yes, go to 18.

☐ Yes ☐ No

Q15. Does the patient have the diagnosis of ankylosing spondylitis?

☐ Yes ☐ No

Q16. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q17. Is there documentation of inadequate response, intolerance or contraindication to at least two non-steroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes ☐ No

Q18. Is Enbrel being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No

Q19. Is Enbrel being prescribed by or in consultation with a dermatologist?

☐ Yes ☐ No

Q20. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q21. Was the tuberculin skin test negative?

☐ Yes ☐ No

Q22. Has the patient received appropriate prophylaxis in accordance with Centers for Disease Control and Prevention (CDC) guidelines?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q23. Additional Information:	

Prescriber Signature _____ Date _____

v2025