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. Will the patient be taking this drug concomitantly with another biologic Disease Modifying Anti-Rheumatic Drug (DMARD) or a targeted synthetic DMARD?

☐ Yes ☐ No

Q2. Is the patient within the age group listed in the FDA labeling for the indication?

☐ Yes ☐ No

Q3. Is this a reauthorization request?

☐ Yes ☐ No

Q4. Is there confirmation of continued positive clinical response since starting Enbel?

☐ Yes ☐ No

Q5. Are chart notes attached documenting a diagnosis of moderately to severely active rheumatoid arthritis (RA), moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA), or active juvenile psoriatic arthritis (JPsA)?

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☐ Yes ☐ No

Q6. Is there documentation of inadequate response, intolerance, or contraindication to at least one conventional DMARD (e.g., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine?

☐ Yes ☐ No

Q7. Are chart notes attached documenting a diagnosis of moderate to severe plaque psoriasis (PsO) and the patient is a candidate for systemic therapy or phototherapy?

☐ Yes ☐ No

Q8. Is there documentation of inadequate response, intolerance, or contraindication to one of the following: methotrexate, ultraviolet-B (UVB) therapy, or acitretin?

☐ Yes ☐ No

Q9. Are chart notes attached documenting a diagnosis of ankylosing spondylitis or non-radiographic axial spondyloarthritis?

☐ Yes ☐ No

Q10. Is there documentation of inadequate response, intolerance, or contraindication to two non-steroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes ☐ No

Q11. Are chart notes attached documenting an FDA-approved diagnosis not otherwise excluded from part D?

☐ Yes ☐ No

Q12. Is Enbrel being prescribed by or in consultation with an appropriate specialist such as a rheumatologist or dermatologist?

☐ Yes ☐ No

Q13. Additional Information:

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

v2025