Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Enbrel® (etanercept)

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners 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:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: ☐ Medicaid ☐ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 the medication prescribed by a rheumatologist or dermatologist or is in consultation with one?

☐ Yes ☐ No

Q2. What is the patient's diagnosis?

☐ Moderately to severely active rheumatoid arthritis (RA) in adults.
☐ Psoriatic arthritis (PsA) in adults.
☐ Plaque psoriasis (PsO) in patients 4 years or older who are candidates for systemic therapy or phototherapy.
☐ Moderately to severely active polyartricluar juvenile idiopathic arthritis (JIA) in patients 2 years of age or older
☐ Ankylosing spondylitis (AS) in adults.

Q3. Has the patient failed or had an inadequate response to the trial of at least one or more DMARD OR is intolerant to DMARDs [e.g., Imuran® (azathioprine), Ridaura® (oral gold), Plaquenil® (hydroxychloroquine), Cuprimine® (D-penicillamine), Azulfidine® (sulfasalazine), methotrexate and NSAIDs]?

☐ Yes ☐ No

Q4. For plaque psoriasis (Ps), is there greater than 10% of the body involvement)?

☐ Yes ☐ No

Q5. For plaque psoriasis (Ps) - greater than 10% of the body involvement: Has the patient failed or had an inadequate response to the trial of Methotrexate OR UVB therapy (alone or in combination with other medications) OR Soriatane (requires prior authorization)?

☐ Yes ☐ No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Enbrel® (etanercept)

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners 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:**

Q6. For plaque psoriasis (Ps) - less than 10% of the body surface area involvement: Has the patient failed or had an inadequate response to the trial of Tar, one topical steroid (high to very high potency for body),AND Dovonex (for body), tacrolimus (for face and other sensitive areas)?

☐ Yes ☐ No

Q7. For polyartricluar juvenile idiopathic arthritis (JIA) - Has the patient failed or had an inadequate response to the trial of one or more DMARD or is intolerant to DMARDs [e.g., NSAIDs, Azulfudine® (sulfasalazine), methotrexate, Imuran® (azathioprine), Ridaura® (oral gold), cyclosporine, prednisone]?

☐ Yes ☐ No

Q8. For ankylosing spondylitis (AS) - Has the patient failed or had an inadequate response to the trial of at least one or more DMARD or is intolerant to DMARDs [e.g., NSAIDs, Azulfudine® (sulfasalazine), methotrexate]?

☐ Yes ☐ No

Q9. Has the patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q10. Is the tuberculin skin test negative?

☐ Yes ☐ No

Q11. If latent infection is diagnosed, has the patient received appropriate prophylaxis in accordance with the CDC and prevention guidelines should be instituted?

☐ Yes ☐ No

Q12. Has the patient been evaluated for Hepatitis B (HBV)?

☐ Yes ☐ No

Q13. Does the patient have acute hepatitis B (HBV) or have chronic hepatitis B (HBV) with Child Pugh class B or C?

☐ Yes ☐ No

Q14. Is the patient being treated for any other active infection?

☐ Yes ☐ No

Q15. Has patient's immunizations been brought up to date?

☐ Yes ☐ No

Q16. Requested Duration:

☐ 12 Months

Q17. Additional Information:

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Enbrel® (etanercept)

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:**

Prescriber Signature

Date

Updated 2018

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document