



2024 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.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax, Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, 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.

Form with fields: 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 or psoriatic 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:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Does the patient have the diagnosis of plaque psoriasis? If No, go to 11.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is the patient 4 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the disease moderate to severe?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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 (requires prior authorization)? If Yes, go to 18.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. 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 18.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Does the patient have the diagnosis of polyarticular juvenile idiopathic arthritis (JIA)? If No, go to 14.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Is the patient 2 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Is there documentation of inadequate response, intolerance or contraindication to one or more disease modifying anti-rheumatic drug (DMARD) OR is intolerant to DMARDS (e.g., sulfasalazine, methotrexate)? If Yes, go to 17.	



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Does the patient have the diagnosis of ankylosing spondylitis?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Is there documentation of inadequate response, intolerance or contraindication to at least two or more non-steroidal anti-inflammatory drugs (NSAIDs) OR is intolerant to NSAIDs?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Is Enbrel being prescribed by or in consultation with a rheumatologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Is Enbrel being prescribed by or in consultation with a dermatologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Was the tuberculin skin test negative?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q21. Has the patient received appropriate prophylaxis in accordance with Centers for Disease Control and Prevention (CDC) guidelines?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q22. Additional Information:	

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Patient Name:	Prescriber Name:

Prescriber Signature

Date

2024 Prior Authorization Request