

Neighborhood Health Plan of Rhode Island Prior Authorization Form Enbrel® (Etanercept)

Member Name: (required)	Member ID Number: (required)
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)

Prescriber Name: (required)	Contact Person at Office:
Office Phone number: (required) () -	Office Fax Number: (required) () -

INDICATIONS FOR USE

YES NO

1) FOR REDUCTION IN SIGNS AND SYMPTOMS AND INHIBITION OF THE PROGRESSION OF STRUCTURAL DAMAGE IN PATIENTS WITH MODERATELY TO SEVERELY ACTIVE RHEUMATOID ARTHRITIS (RA).	<input type="checkbox"/>	<input type="checkbox"/>
2) FOR THE REDUCTION IN SIGNS AND SYMPTOMS OF ARTHRITIS IN PATIENTS WITH PSORIATIC ARTHRITIS.	<input type="checkbox"/>	<input type="checkbox"/>
3) FOR REDUCTION IN SIGNS AND SYMPTOMS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR-COURSE JUVENILE RHEUMATOID ARTHRITIS IN PATIENTS WHO HAVE HAD AN INADEQUATE RESPONSE TO ONE OR MORE DISEASE MODIFYING ANTIRHEUMATIC DRUGS	<input type="checkbox"/>	<input type="checkbox"/>
4) FOR THE REDUCTION OF SIGNS AND SYMPTOMS IN PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS	<input type="checkbox"/>	<input type="checkbox"/>
5) FOR THE TREATMENT OF PATIENTS AGED > 18 YEARS WITH CHRONIC MODERATE TO SEVERE PLAQUE PSORIASIS WHO ARE CANDIDATES FOR SYSTEMIC THERAPY OR PHOTOTHERAPY.	<input type="checkbox"/>	<input type="checkbox"/>
6) IF ENBREL IS BEING USED FOR TREATMENT OF PSORIASIS HAS PATIENT FAILED SYSTEMIC THERAPY WITH ANY OF THE FOLLOWING (CIRCLE ALL THAT APPLY)? METHOTREXATE, CYCLOSPORINE, ACITRETIN, PHOTOTHERAPY WITH UVB OR PUVA	<input type="checkbox"/>	<input type="checkbox"/>
7) PATIENT HAS HAD AN UNSATISFACTORY RESPONSE TO A PREVIOUS TRIAL OF A DISEASE MODIFYING ANTIRHEUMATIC DRUG (DMARD) OR PREVIOUS TNF THERAPY (I.E. HYDROXYCHLOROQUINE (PLAQUENIL®), AZATHIOPRINE (MURAN®), SULFASALAZINE (AZULFIDINE®), CYCLOPHOSPHAMIDE (CYTOXAN®), CYCLOSPORINE (NEORAL®), METHOTREXATE), ANAKINRA (KINERET®), ETC PLEASE LIST PRIOR THERAPIES: a) _____ b) _____ c) _____	<input type="checkbox"/>	<input type="checkbox"/>
8) IF THIS IS FOR RENEWAL, HAS PATIENT SHOWN SYMPTOMATIC IMPROVEMENT? PLEASE DESCRIBE: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
9) DOES THE PATIENT HAVE SEPSIS?	<input type="checkbox"/>	<input type="checkbox"/>
10) IS THE PATIENT HYPERSENSITIVE TO ENBREL OR ANY OF ITS COMPONENTS?	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> ▪ Patients should be evaluated for latent tuberculosis with a tuberculin skin test prior to etanercept therapy. ▪ Treatment of latent TB should be initiated before infliximab is used. ▪ Rare reactivation of hepatitis B has occurred in chronic virus carriers. ▪ Use caution in patients with pre-existing or recent-onset demyelinating CNS disorders. 		

INITIAL APPROVAL WILL BE FOR 4 MONTHS AT WHICH TIME PATIENT SHOULD BE EVALUATED FOR RESPONSE TO THERAPY. IF PATIENT IS RESPONDING TO THERAPY, AN ADDITIONAL 9 MONTHS WILL BE APPROVED.

Directions for Enbrel _____

Provider Signature: _____ **NPI** _____ **Date:** _____

Please fax to (866) 423-0945