



Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Enbrel

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. Which drug is being prescribed? Enbrel, Dose: _____ Frequency: _____
 Other _____
2. What is the diagnosis?
 Ankylosing Spondylitis Psoriatic Arthritis Polyarticular Juvenile Idiopathic Arthritis
 Rheumatoid Arthritis Plaque Psoriasis Other _____
3. How old is the patient? _____ **years**
4. What is the medical specialty of the prescribing physician?
 Rheumatologist Dermatologist Gastroenterologist
 Colorectal Specialist Other _____
5. Does the patient have negative tuberculosis (TB) test? **If yes, skip to # 8* Yes No
6. Has active TB been ruled out via negative chest x-ray? Yes No
7. Was chest x-ray taken within last 12 months? Yes No
8. Does the patient have signs or symptoms of active infection, either chronic or localized? Yes No
9. Does the patient have a history of hepatitis B infection? Yes No
10. Has the patient been treated for hepatitis B infection? Yes No
11. Does the patient have a history of any of the following diseases? Yes No
 Congestive cardiac failure (New York Heart Association grade III or IV)
 Multiple sclerosis or other demyelinating disease
 Malignant disease
12. Will Enbrel be used in combination with any other biologic medication(s)? Yes No
13. Is the patient currently receiving Enbrel therapy? Yes No **If no, skip to # 15*
14. Did the patient demonstrate a therapeutic response? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

15. Has the patient had a trial of biologic therapy other than Enbrel for 3 consecutive months?
 Yes No **If no, skip to # 18*
 Cimzia Humira Kineret Orencia Remicade Rituxan Simponi
16. Has the patient had an inadequate response to previous biologic therapy? Yes No
17. Was the patient adherent to prescribed biologic therapy? Yes, **submit documentation** No
18. Was the patient intolerant to previous biologic therapy? Yes, **submit documentation** No

Section A: Rheumatoid Arthritis

19. Prior to therapy, did the patient have 6 or more inflamed joints? Yes No
20. Prior to therapy, did the patient have at least one of the following characteristics? Yes No
 Elevation of erythrocyte sedimentation rate and/or serum c-reactive protein concentration
 Positive rheumatoid factor and/or anti-cyclic citrullinated peptide
 Radiography showing evidence of rheumatoid arthritis, including osteopenia and/or joint space narrowing and/or bony erosions and/or loss of cartilage
21. Has the patient had a trial of either methotrexate or leflunomide for at least 3 consecutive months?
 Yes No **If no, skip to # 23*
22. Has the patient had an inadequate response to either methotrexate or leflunomide?
**If yes, skip to # 27* Yes No
23. Is the patient intolerant or contraindicated to either methotrexate or leflunomide? Yes No
24. Has the patient had a trial of another nonbiologic DMARD for at least 3 consecutive months (e.g., hydroxychloroquine, cyclosporine, sulfasalazine, gold, azathioprine)? Yes No
25. Has the patient had an inadequate response to such therapy? Yes No
26. Is the patient intolerant or contraindicated to such therapy? Yes No
27. Was the patient adherent to prescribed therapy? Yes No
28. **Submit documentation** of last trial of nonbiologic DMARD.

Section B: Ankylosing Spondylitis

29. Does the patient have axial disease? Yes No **If no, skip to # 32*
30. Has the patient had a trial of at least one non-steroidal anti-inflammatory drug (NSAID) or COX-2 inhibitor for at least 3 consecutive months? Yes No **If no, skip to # 35*
31. Is the patient intolerant or contraindicated to NSAIDs and COX-2 inhibitors?
**Skip to # 37* Yes No
32. Does the patient have peripheral disease? Yes No
33. Has the patient had a trial of either methotrexate or sulfasalazine for at least 3 consecutive months?
**If yes, skip to # 35* Yes No
34. Is the patient intolerant or contraindicated to both methotrexate and sulfasalazine?
**Skip to # 37* Yes No
35. Has the patient had an inadequate response to prescribed therapy? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

36. Was the patient adherent to prescribed therapies? Yes No
37. **Submit documentation** of last trial of conventional therapy unless contraindicated.

Section C: Polyarticular Juvenile Idiopathic Arthritis OR Psoriatic Arthritis

38. For diagnosis of polyarticular juvenile idiopathic arthritis ONLY, prior to therapy, did the patient's arthritis involve more than 4 joints? Yes No
39. Has the patient had a trial of either methotrexate or leflunomide for at least 3 consecutive months?
 Yes No **If no, skip to # 41*
40. Has the patient had an inadequate response to either methotrexate or leflunomide?
**Skip to # 45* Yes No
41. Is the patient intolerant or contraindicated to either methotrexate or leflunomide? Yes No
42. Has the patient had a trial of another non-biologic DMARD for at least 3 consecutive months?
CIRCLE WHICH ONE(S) (e.g., hydroxychloroquine, cyclosporine, sulfasalazine, gold, azathioprine)
 Yes No
43. Has the patient had an inadequate response to such therapy? Yes No
44. Is the patient intolerant or contraindicated to such therapy? Yes No
45. Was the patient adherent to prescribed therapies? Yes No
46. **Submit documentation** of last trial of non-biologic DMARD.

Section D: Plaque Psoriasis

47. What is the percentage of body surface area (BSA) affected? _____ %
48. Does the patient's psoriasis involve palms, soles, face and neck or genitalia? Yes No
49. Has the patient had a trial of ALL three of the following therapies for 3 consecutive months?
 Yes No **If no, skip to # 52*
 Topical treatment (e.g., calcipotriene, tazarotene, coal tar preparation, anthralin, medium to high potency corticosteroids)
 Phototherapy
 One systemic therapy (e.g., methotrexate, thioguanine, cyclosporine, acitretin)
50. Has the patient had an inadequate response to such therapies? Yes No
51. Was the patient adherent to each prescribed therapy? Yes No
52. Is the patient contraindicated or intolerant to such therapies? Yes No
53. **Submit documentation** of last trial of conventional therapy unless contraindicated.

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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