

PRIOR AUTHORIZATION REQUEST FORM

Enbrel

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Product Requested: Enbrel (etanercept)

Directions for Use: _____

PART I: Criteria for Approval: (All of the following criteria must be met) - Then move to PART II	Yes	No
1. Is the medication being prescribed by or in consultation with a provider specializing in the disease treatment?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have any of the following diagnoses? (check the applicable) <input type="checkbox"/> Ankylosing Spondylitis (AS) <input type="checkbox"/> Juvenile Psoriatic Arthritis (JPsA) <input type="checkbox"/> Plaque Psoriasis (PsO) <input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (pJIA) <input type="checkbox"/> Psoriatic Arthritis (PsA) <input type="checkbox"/> Rheumatoid Arthritis (RA) <input type="checkbox"/> Other - Off Label or Compendia Use (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the requested medication and diagnosis follow FDA-approved age, dosing, monitoring and contraindications? If answer is No, go to Part II, section 7	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the provider attest that the patient is not taking concurrent treatment or will not be used in combination with other TNF-inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, member medication fill history, or submitted documentation?	<input type="checkbox"/>	<input type="checkbox"/>

PART II: Select and fill out applicable sections:

Section 1: Additional criteria for Ankylosing Spondylitis (AS) (All of the following criteria must be met)

1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of Ankylosing Spondylitis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient tried and failed, demonstrated an intolerance to, or has a contraindication to at least two different prescription strength nonsteroidal anti-inflammatory drugs (NSAID) at the maximally tolerated dose for at least 1 month each?	<input type="checkbox"/>	<input type="checkbox"/>

Section 2: Additional criteria for Juvenile Psoriatic Arthritis (JPsA) (All of the following criteria must be met)		
1. Is the patient at least 12 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of moderately to severely active Juvenile Psoriatic Arthritis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient tried and failed, or intolerance/contraindication to, to one NSAID or glucocorticoid for 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the patient have a trial and failure/ intolerance/contraindication to methotrexate or leflunomide for 3 months, if clinically appropriate?	<input type="checkbox"/>	<input type="checkbox"/>
Section 3: Additional criteria for Plaque Psoriasis (PsO) (All of the following criteria must be met)		
1. Is the patient at least 4 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the patient been diagnosed with moderate to severe plaque psoriasis involving greater than 3% body surface area?	<input type="checkbox"/>	<input type="checkbox"/>
3. If less than 3% of the body is involved, is there scalp, palmar, foot, or groin involvement causing significant disability?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the patient tried and failed for at least 3 months of at least ONE of the following medications if clinically appropriate, or contraindicated to all 3? <input type="checkbox"/> methotrexate <input type="checkbox"/> cyclosporine <input type="checkbox"/> acitretin therapy	<input type="checkbox"/>	<input type="checkbox"/>
Section 4: Additional criteria for Polyarticular Juvenile Idiopathic Arthritis (JIA) (All of the following criteria must be met)		
1. Is the patient at least 2 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the patient have a trial and failure, intolerance or contraindication to one NSAID or glucocorticoid for 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the patient have a trial and failure, intolerance or contraindication to methotrexate or leflunomide for 3 months, if clinically appropriate?	<input type="checkbox"/>	<input type="checkbox"/>
Section 5: Additional criteria for Psoriatic Arthritis (PsA) (All of the following criteria must be met)		
1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of active psoriatic arthritis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient had an adequate trial and failure of at least ONE of the following disease-modifying antirheumatic drugs (DMARDs) for at least 3 months (if clinically appropriate), unless all are contraindicated: methotrexate, leflunomide, sulfasalazine, azathioprine?	<input type="checkbox"/>	<input type="checkbox"/>
Section 6: Additional criteria for Rheumatoid Arthritis (RA) (All of the following criteria must be met)		
1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the member had an adequate trial and failure of at least ONE disease modifying antirheumatic drug (DMARD), if clinically appropriate, for at least 3 months (e.g. hydroxychloroquine, leflunomide, methotrexate, sulfasalazine) or contraindication to all?	<input type="checkbox"/>	<input type="checkbox"/>
Section 7: Other - Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion:		
1. Does the clinical documentation show an adequate trial and failure with at least ONE FDA-labeled and Medicaid preferred medication, if applicable?	<input type="checkbox"/>	<input type="checkbox"/>
2. Provider attest the requested drug is being used for a medically accepted indication that is supported by information from the appropriate compendia* of current literature. Including at least (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, or other peer review specialty medical journals in the most recent years? * Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), the Micromedex Information System, Pediatric and Neonatal Lexi-Drugs, or clinical guidelines.	<input type="checkbox"/>	<input type="checkbox"/>
Reauthorization		
1. Has the provider submitted an updated letter with medical justification and updated chart notes demonstrating positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>
PRESCRIBER CERTIFICATION		
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.		

Physician's Signature:	Date:
------------------------	-------

Initial Authorization: Up to six (6) months

Reauthorization: Up to one (1) year

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Note:

- WARNING: SERIOUS INFECTIONS AND MALIGNANCY
 - SERIOUS INFECTIONS
 - Patients treated with Enbrel are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids.
 - Enbrel should be discontinued if a patient develops a serious infection or sepsis.
 - MALIGNANCY
 - Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF-blockers, including Enbrel.

Policy: PHARM-HYB-175
Origination Date: 01/01/2026
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 01/01/2026

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.