



Prior Authorization
<p>JOHNS HOPKINS HEALTH PLANS Enbrel - Priority Partners MCO</p> <p>This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at 1-410-424-4607. Please contact Johns Hopkins Health Plans at 1-888-819-1043 with questions regarding the Prior Authorization process.</p> <p>When conditions are met, we will authorize the coverage of Enbrel - Priority Partners MCO.</p>

Drug Name (select from list of drugs shown) ENBREL (etanercept)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	

[If yes, skip to question 24.]	
2. Does the patient have ANY of the following diagnoses: A) uveitis, B) sarcoidosis, C) graft-versus-host disease, D) interleukin-2 toxicity, E) Langerhans cell histiocytosis, F) myositis, G) nephrotic syndrome, H) amyloidosis, I) periodic fever syndrome, J) renal transplant syndrome, OR K) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
3. Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 7.]	
4. Has the patient had treatment failure with at least TWO formulary disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 23.]	
5. Does the patient have a contraindication to at least TWO formulary disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 23.]	
6. Has the patient had rheumatoid arthritis for less than or equal to 6 months with high level of disease activity and features of poor prognosis (such as extra-articular disease, positive rheumatoid factor, or bony erosions)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 23.]	
[If no, no further questions.]	
7. Does the patient have a diagnosis of moderately to severely active juvenile idiopathic arthritis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 11.]	
8. Has the patient tried and had insufficient response to an adequate trial of full dose nonsteroidal anti-inflammatory drug (NSAID) therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Has the patient tried and had insufficient response to at least TWO disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 21.]	

10. Does the patient have a contraindication to at least TWO disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 21.]	
[If no, no further questions.]	
11. Does the patient have a diagnosis of active psoriatic arthritis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 14.]	
12. Has the patient tried and had insufficient response to at least TWO disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 21.]	
13. Does the patient have a contraindication to at least TWO disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 21.]	
[If no, no further questions.]	
14. Does the patient have a diagnosis of active ankylosing spondylitis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 16.]	
15. Has the patient tried and had insufficient response to an adequate trial of TWO full dose nonsteroidal anti-inflammatory drug (NSAID) therapies?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 23.]	
[If no, no further questions.]	
16. Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
17. Does the patient have EITHER of the following: A) body surface area involvement of greater than 10 percent OR B) body surface area involvement of less than or equal to 10 percent, but involves sensitive areas (palms/soles of feet, genitalia and head/neck)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	

18. Has the patient tried and had insufficient response or contraindication to at least ONE of the following: A) phototherapy OR B) systemic therapy with methotrexate or cyclosporine?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
19. Does the patient have moderate disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 22.]	
20. Has the patient had a documented trial and insufficient response to topical pharmacologic therapy (corticosteroids, vitamin D analogues, or retinoids), unless their use is contraindicated?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 22.]	
[If no, no further questions.]	
21. Is the patient 2 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 27.]	
[If no, no further questions.]	
22. Is the patient 4 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 27.]	
[If no, no further questions.]	
23. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 27.]	
[If no, no further questions.]	
24. Does the patient have ANY of the following diagnoses: A) uveitis, B) sarcoidosis, C) graft-versus-host disease, D) interleukin-2 toxicity, E) Langerhans cell histiocytosis, F) myositis, G) nephrotic syndrome, H) amyloidosis, I) periodic fever syndrome, J) renal transplant syndrome, OR K) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
25. Does the patient have ONE of the following diagnoses: A) rheumatoid arthritis, B) juvenile idiopathic arthritis, C) psoriatic arthritis, D) ankylosing spondylitis, OR E) plaque psoriasis?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
26. Is the patient experiencing clinical improvement from treatment as supported by ONE of the following outcomes: A) reduction in the signs and symptoms, B) prolonged beneficial clinical response, C) inhibition of structural damage progression, OR D) improved physical functioning?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	

[If no, no further questions.]	
27. Is the requested medication being prescribed for FDA-approved dosages and dosing intervals?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
28. Will the requested medication be used concurrently with another biologic disease-modifying anti-rheumatic drug (DMARD)?	<input type="checkbox"/> Y <input type="checkbox"/> N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date
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