Prior Authorization Request Form for etanercept **(Enbrel)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **3**	☐ No proceed to question **2**
2. Is the patient between the ages of 4 and 17 years old AND has a diagnosis of plaque psoriasis?	☐ Yes proceed to question **6**	☐ No proceed to question **5**
3. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **6**	☐ No proceed to question **4**
4. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers, including ENBREL. Is the prescriber aware of this?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient 18 years of age or older?	☐ Yes proceed to question **9**	☐ No proceed to question **8**

8. Is the patient 2 to 17 years of age? (that is, age 2 through 17 years)		☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
9. What is the indication or diagnosis in this adult patient?	☐ Moderate to severe active **rheumatoid arthritis** – Proceed to question **11** ☐ Active **psoriatic arthritis** – Proceed to question **11** ☐ active **ankylosing spondylitis** – Proceed to question **12** ☐ Moderate to severe chronic **plaque psoriasis** in a patient who may benefit from taking injection or pills (systemic therapy) or phototherapy – Proceed to question **11** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**		
10. What is the indication or diagnosis in this pediatric patient?	☐ Moderate to severe active polyarticular **juvenile idiopathic arthritis** – Proceed to question **13** ☐ **Plaque psoriasis AND is over the age of 4** – Proceed to question **13** ☐ Other indication, age or diagnosis – **STOP: Coverage not approved.**		
11. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)		☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
12. Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?		☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?		☐ Yes proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Will the patient be receiving other targeted immunomodulatory biologics with Enbrel, including but not limited to the following: Actemra, Cimzia, Cosentyx, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?		☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[24 April 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: