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

JOHNS HOPKINS
HEALTH PLANS
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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.

Prior Authorization does not expire.

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

Question	Yes	No
1. Humira is the Department of Defense's preferred targeted biologic agent for adults and children. Has the patient tried Humira?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient 18 years of age or older?	☐ Yes proceed to question **7**	☐ No proceed to question **6**

Question		
6. Is the patient 2 to 17 years of age? (that is, age 2 through 17 years)	☐ Yes proceed to question **8**	☐ No **STOP Coverage not approved**
7. What is the indication or diagnosis in this adult patient?	☐ Moderate to severe active **rheumatoid arthritis** – Proceed to question **9** ☐ Moderate to severe active **psoriatic arthritis** – Proceed to question **9** ☐ Moderate to severe active **ankylosing spondylitis** – Proceed to question **10** ☐ Moderate to severe chronic **plaque psoriasis** in a patient who are candidates for systemic or phototherapy – Proceed to question **9** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
8. What is the indication or diagnosis in this pediatric patient?	☐ Moderate to severe active polyarticular **Juvenile Idiopathic Arthritis** – Proceed to question **9** ☐ **Plaque psoriasis** – Proceed to question **11** ☐ **Juvenile Psoriatic Arthritis** – Proceed to question **9** ☐ Other indication, age or diagnosis – **STOP: Coverage not approved.**	
9. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)	☐ Yes proceed to question **13**	☐ No **STOP Coverage not approved**
10. 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**
11. What is the age of the patient?	☐ LESS than 4 years of age - **STOP Coverage not approved** ☐ 4 years of age to LESS than 6 years of age - proceed to question **13** ☐ 6 years of age and OLDER - proceed to question **12**	
12. Has the patient had a trial of Stelara?	☐ Yes proceed to question **13**	☐ No **STOP Coverage not approved**
13. Does the patient have 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. 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 **15**	☐ No **STOP Coverage not approved**
15. 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, Rinvoq, Rituxan, Siliq, Simponi, Skyrizi, 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

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