

Enbrel

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:		
Provider First Name:		Provider Last Name:		
Provider Phone:		Provider Fax:		Provider NPI #:
Patient Name:		Patient UPMC Health Plan ID Number:		Patient DOB:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:	Patient Age:

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	
Please indicate place of administration? <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Facility		Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please provide facility/provider name and address:			

Please complete the following questions for all diagnoses.

Please indicate disease severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Is there evidence of Infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Date of PPD (tuberculin) test:	Result of PPD test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Is the member currently using another TNF-blocking agent or biologic agent in combination with Enbrel? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please indicate drug name:			

Please indicate the diagnosis on the left and complete the corresponding questions.

<input type="checkbox"/> Rheumatoid Arthritis	Has the member tried and failed Methotrexate for at least 3 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please provide dates of therapy and dose:		
	Reason for discontinuation:		
	<input type="checkbox"/> Juvenile Idiopathic Arthritis	Please indicate if the member tried and failed any of the following for at least 3 months?	
<input type="checkbox"/> Leflunomide (Arava)		<input type="checkbox"/> Minocycline (Minocin)	
<input type="checkbox"/> Sulfasalazine (Azulfidine)		<input type="checkbox"/> Hydroxychlorquine (Plaquenil)	
Please provide dates of therapy and dose:			
Reason for discontinuation:			
<input type="checkbox"/> Psoriatic Arthritis	Does the member have dominant peripheral disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member have dominant axial disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please indicate if the member tried and failed any of the following for at least 3 months?		
	<input type="checkbox"/> Cyclosporine (Neoral, Sandimmune)	<input type="checkbox"/> Sulfasalazine (Azulfidine)	
	<input type="checkbox"/> Leflunomide (Arava)	<input type="checkbox"/> Methotrexate	
	Please provide dates of therapy and dose:		
Reason for discontinuation:			

Please be sure to complete and include the 2nd page of this form

ENBREL
Page 2

Patient Name

Patient UPMC Health Plan ID Number:

Patient DOB:

Please be sure to complete and include this page with the 1st page of this form

<input type="checkbox"/> Psoriatic Arthritis (cont)	Has the member tried and failed any NSAIDs for at least 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please indicate drug name(s):	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	

<input type="checkbox"/> Ankylosing Spondylitis	Does the member have dominant peripheral disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member have dominant axial disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please indicate if the member tried and failed any of the following for at least 3 months? <input type="checkbox"/> Methotrexate <input type="checkbox"/> Sulfasalazine (Azulfidine)	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
	Has the member tried and failed any NSAIDs for at least 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please indicate drug name(s) and dose:	
	Please provide dates of therapy:	
Reason for discontinuation:		

<input type="checkbox"/> Plaque Psoriasis	Please indicate body surface area (BSA) <input type="checkbox"/> Less than 10% <input type="checkbox"/> Greater than or equal to 10% involvement:	
	Does the member have psoriasis on the palms, soles, head, neck, or genitalia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has the member tried and failed topical treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, indicate drug name :	
	Reason for discontinuation:	
	Has the member tried and failed phototherapy or photochemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please indicate if the member tried and failed any of the following for at least 3 months? <input type="checkbox"/> Methotrexate <input type="checkbox"/> Cyclosporine (Neoral, Sandimmune) <input type="checkbox"/> Acitretin (Soriatane)	
	Please provide dates of therapy and dose:	
Reason for discontinuation:		

Please provide any additional information which should be considered in the space below:

