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.

❑ New medication **❑ Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did the member show improvement while on therapy?**	**❑ Yes** **❑ No**

Diagnosis:	**Date of diagnosis:**

Please indicate place of administration?	❑Physician's Office ❑Hospital/Facility	**Please indicate how medication will be billed:** ❑ Billed directly by the provider via JCODE Provide JCODE:_____ ❑ Billed by a pharmacy and delivered to the provider ❑ 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:	❑Mild	❑ Moderate	❑Severe
Is there evidence of Infection?	❑ Yes	❑ No	
Date of PPD (tuberculin) test:	Result of PPD test: ❑ Positive	❑Negative	
Is the member currently using another TNF-blocking agent or biologic agent in combination with Enbrel?	❑Yes	❑No	
If yes, please indicate drug name:			

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

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

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

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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

❑ Psoriatic Arthritis (cont)	Has the member tried and failed any NSAIDs for at least 3 months?	❑Yes ❑No
	Please indicate drug name(s):	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
❑ Ankylosing Spondylitis	Does the member have dominant **peripheral** disease?	❑Yes ❑No
	Does the member have dominant **axial** disease?	❑Yes ❑No
	Please indicate if the member tried and failed any of the following for at least 3 months? ❑Methotrexate ❑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?	❑Yes ❑No
	Please indicate drug name(s) and dose:	
	Please provide dates of therapy:	
	Reason for discontinuation:	
❑ Plaque Psoriasis	Please indicate body surface area (BSA) involvement: ❑Less than 10% ❑Greater than or equal to 10%	
	Does the member have psoriasis on the palms, soles, head, neck, or genitalia?	❑Yes ❑No
	Has the member tried and failed topical treatments?	❑Yes ❑No
	If yes, indicate drug name :	
	Reason for discontinuation:	
	Has the member tried and failed phototherapy or photochemotherapy	❑Yes ❑No
	Please indicate if the member tried and failed any of the following for at least 3 months? ❑Methotrexate ❑Cyclosporine (Neoral, Sandimmune) ❑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: