maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Enbrel

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the requested medication be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [Note: Examples of biologics include but not limited to adalimumab SC products (Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, Kevzara, Kineret, Orencia (IV or SC), an infliximab product (for example, Remicade, biosimilars), rituximab IV products (Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Ilumya, Skyrizi, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of targeted synthetic DMARD include but not limited to Olumiant, Rinvoq, Xeljanz/XR, Otezla.] [If yes, no further questions.]	Yes	No
2	Is the patient currently receiving an etanercept product?	Yes	No

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	[If no, skip to question 8.]		
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
4	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
5	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Is the requested medication being prescribed by or in consultation with a rheumatologist, dermatologist, ophthalmologist, gastroenterologist, neurologist, oncologist, hematologist, or a physician affiliated with a transplant center? [No further question.]	Yes	No
8	What is the indication or diagnosis? [] Rheumatoid Arthritis (If checked, go to 9) [] Ankylosing Spondylitis (If checked, go to 10) [] Juvenile Idiopathic Arthritis (JIA) (or Juvenile Rheumatoid Arthritis [JRA]) regardless of type of onset. [Note: This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis] (If checked, go to 12) [] Plaque Psoriasis (If checked, go to 18) [] Psoriatic Arthritis (PsA) (If checked, go to 22) [] Behcet's Disease (If checked, go to 25) [] Graft-Versus-Host Disease (GVHD) (If checked, go to 27) [] Pyoderma Gangrenosum (If checked, go to 30) [] Scleritis or Sterile Corneal Ulceration (If checked, go to 32) [] Spondyloarthritis (SpA), Other Subtypes (for example, undifferentiated arthritis, non-radiographic axial SpA, Reactive Arthritis [Reiter's disease]) (If checked, go to 33)		

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[] Still's Disease (systemic-onset rheumatoid arthritis in adults, the disease may have begun in childhood) (If checked, go to 39)

[] Uveitis (including other posterior uveitis and panuveitis syndromes) (If checked, go to 41)

[] Enthesitis-Related Arthritis (If checked, go to 44)

[] Crohn's Disease (If checked, go to 10)

[] Inflammatory Myopathies (Polymyositis, Dermatomyositis, Inclusion Body Myositis) (If checked, no further questions)

[] Hidradenitis Suppurativa (If checked, go to 10)

[] Polymyalgia Rheumatica (PMR) (If checked, no further questions)

[] Sarcoidosis (If checked, no further questions)

[] Large Vessel Vasculitis (for example, Giant Cell Arteritis, Takayasu's Arteritis) (If checked, no further questions)

[] Wegener's Granulomatosis (If checked, no further questions)

[] Other (If checked, no further questions)

9	Has the patient tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months, unless intolerant? [Note: Examples include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
10	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred adalimumab product? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Does the requested dose exceed FDA approved label dosing for the requested indication? [If yes, no further questions.] [If no, skip to question 48.]	Yes	No
12	Has the patient tried one other agent for at least 3 months for this condition? [Note: Examples of other agents for JIA include methotrexate (MTX), sulfasalazine, or leflunomide, a nonsteroidal anti-inflammatory drug (NSAID) (for example, ibuprofen, naproxen).] [If yes, skip to question 15.]	Yes	No

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13	Will the patient be starting on the requested medication concurrently with methotrexate (MTX), sulfasalazine, or leflunomide? [If yes, skip to question 15.]	Yes	No
14	Does the patient have an absolute contraindication to methotrexate (MTX), sulfasalazine, or leflunomide? [Note: Examples of contraindications to MTX include pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias.] [If no, no further questions.]	Yes	No
15	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred adalimumab product? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 17.]	Yes	No
16	Does the patient have aggressive disease, as determined by the prescriber? [If no, no further questions.]	Yes	No
17	Does the requested dose exceed FDA approved label dosing for the requested indication? [If yes, no further questions.] [If no, skip to question 48.]	Yes	No
18	Is the patient greater than or equal to 4 years of age? [If no, no further questions.]	Yes	No
19	Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months, unless intolerant? [Note: Examples include methotrexate (MTX), cyclosporine, acitretin (Soriatane, generics), or psoralen plus ultraviolet A light (PUVA).] [If no, no further questions.]	Yes	No
20	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred adalimumab product? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Does the requested dose exceed FDA approved label dosing for the requested indication? [If yes, no further questions.] [If no, skip to question 49.]	Yes	No
22	Has the patient tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months, unless intolerant? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.]	Yes	No

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	[If no, no further questions.]		
23	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred adalimumab product? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Does the requested dose exceed FDA approved label dosing for the requested indication? [If yes, no further questions.] [If no, skip to question 50.]	Yes	No
25	Has documentation been submitted to confirm that the patient tried at least one conventional therapy for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include systemic corticosteroids (for example, methylprednisolone), immunosuppressants [for example, azathioprine, methotrexate (MTX), mycophenolate mofetil, cyclosporine, tacrolimus, Leukeran (chlorambucil), cyclophosphamide, interferon alfa.] [If no, no further questions.]	Yes	No
26	Is the requested medication being prescribed by or in consultation with a rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist? [No further questions.]	Yes	No
27	Has documentation been submitted to confirm that the patient tried one conventional treatment for graft-versus-host disease (GVHD) for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional treatments the patient may have tried include high-dose systemic corticosteroids, antithymocyte globulin, cyclosporine, thalidomide, tacrolimus, mycophenolate mofetil.] [If yes, skip to question 29.]	Yes	No
28	Will the patient be concurrently receiving at least one of these medications (for example, high-dose systemic corticosteroids, antithymocyte globulin, cyclosporine, Thalomid [thalidomide capsules], tacrolimus, mycophenolate mofetil) in combination with the requested medication? [If no, no further questions.]	Yes	No
29	Is the requested medication being prescribed by or in consultation with an oncologist, hematologist, or a physician affiliated with a transplant center? [No further questions.]	Yes	No
30	Has documentation been submitted to confirm that the patient tried one systemic corticosteroid for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 49.]	Yes	No

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31	Has documentation been submitted to confirm that the patient tried one other immunosuppressant for at least 2 months or was intolerant to one of these agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include mycophenolate mofetil and cyclosporine.] [If yes, skip to question 49.] [If no, no further questions.]	Yes	No
32	Has documentation been submitted to confirm that the patient tried one other therapy for at least 3 months for the requested indication? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include oral nonsteroidal anti-inflammatory drugs (NSAIDs) such as indomethacin, naproxen, or ibuprofen; oral, topical (ophthalmic) or IV corticosteroids (such as prednisone, prednisolone, methylprednisolone); methotrexate (MTX); cyclosporine; or other immunosuppressants.] [If yes, skip to question 51.] [If no, no further questions.]	Yes	No
33	Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet? [If no, skip to question 35.]	Yes	No
34	Has documentation been submitted to confirm that the patient tried at least ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include methotrexate (MTX), leflunomide, sulfasalazine.] [If yes, skip to question 48.]	Yes	No
35	Does the patient have axial spondyloarthritis? [If no, no further questions.]	Yes	No
36	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred adalimumab product? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
37	Does the patient have objective signs of inflammation, defined as C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory? [If yes, skip to question 48.]	Yes	No
38	Does the patient have objective signs of inflammation, defined as sacroiliitis reported on magnetic resonance imaging (MRI)? [If yes, skip to question 48.] [If no, no further questions.]	Yes	No
39	Has documentation been submitted to confirm that the patient tried one	Yes	No

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	corticosteroid for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
40	Has the patient tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 2 months or was intolerant to a conventional synthetic DMARD? [Note: An example is methotrexate.] [If yes, skip to question 48.] [If no, no further questions.]	Yes	No
41	Has documentation been submitted to confirm that the patient tried one periocular, intraocular, or systemic corticosteroids for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of corticosteroids include prednisolone, triamcinolone, betamethasone, methylprednisolone, and prednisone.] [If yes, skip to question 43.]	Yes	No
42	Has documentation been submitted to confirm that the patient tried one immunosuppressive for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of immunosuppressive include methotrexate (MTX), mycophenolate mofetil, azathioprine, and cyclosporine.] [If no, no further questions.]	Yes	No
43	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred adalimumab product? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 51.] [If no, no further questions.]	Yes	No
44	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
45	Has documentation been submitted to confirm that the patient tried at least one systemic agent for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of systemic agents include NSAIDs such as ibuprofen and naproxen.] [If yes, skip to question 47.]	Yes	No
46	Has documentation been submitted to confirm that the patient has an intolerance to at least two systemic agents? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
47	Does the requested dose exceed FDA approved label dosing for the requested	Yes	No

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	indication? [If yes, no further questions.]		
48	Is the requested medication being prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No
49	Is the requested medication being prescribed by or in consultation with a dermatologist? [No further questions.]	Yes	No
50	Is the requested medication being is prescribed by or in consultation with a rheumatologist or a dermatologist? [No further questions.]	Yes	No
51	Is the requested medication being prescribed by or in consultation with an ophthalmologist?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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