PARAMOUNT
Affiliate of ProMedica

CRITERIA: PMT
APPROVED: 11/2014
VERIFIED: 12/4/19
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Enbrel

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025**. You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Enbrel.

Drug Name (select from list of drugs shown)

Enbrel (etanercept) Other, Please specify

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the patient previously received Enbrel for one of the following conditions: A) Rheumatoid arthritis, B) Polyarticular juvenile idiopathic arthritis, C) Ankylosing spondylitis, D) Axial spondyloarthritis, E) Psoriatic arthritis, F) Plaque psoriasis? Y N
   [If yes, skip to question 3.]
2. Has documentation to support continued clinical effectiveness been submitted with the renewal request? Y N
   [No further questions.]
3. Is Enbrel requested for a patient with moderately to severely active rheumatoid arthritis (RA)? Y N
   [If no, skip to question 5.]
4. Does the patient meet either of the following criteria: A) Patient had an inadequate response, intolerance, or contraindication to methotrexate (MTX), or B) Patient had an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab) or a targeted synthetic DMARD (e.g., tofacitinib)? Y N

[No further questions.]

5. Is Enbrel requested for a patient with moderately to severely active polyarticular juvenile idiopathic arthritis? Y N
   [If no, skip to question 7.]
6. Does the patient meet either of the following criteria: A) Patient has had an inadequate response, intolerance or contraindication to methotrexate (MTX), or B) Patient has had an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab)? Y N
   [No further questions.]
7. Is Enbrel requested for a patient with active psoriatic arthritis? Y N
   [If yes, no further questions.]
8. Is Enbrel requested for a patient with active ankylosing spondylitis or axial spondyloarthritis? Y N
   [If no, skip to question 10.]
9. Has the patient had an inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial at maximum recommended or tolerated dose OR has intolerance or contraindication to NSAIDs? Y N
   [No further questions.]
10. Is Enbrel requested for a patient with chronic moderate to severe plaque psoriasis? Y N
    [If no, no further questions.]
11. Does the patient meet one of the following criteria: A) At least 5 percent of body surface area was affected by plaque psoriasis at the time of diagnosis, B) Crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) were affected by plaque psoriasis at the time of diagnosis? Y N
    [If no, no further questions.]
12. Does the patient have an inadequate response, intolerance or contraindication to BOTH of the following: A) a three to four month trial of phototherapy, B) a three to four month trial of pharmacologic treatment with methotrexate, cyclosporine, or acitretin? Action Required: If Yes , attach office notes and clinical documentation for the response given. Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date