Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Enbrel (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Enbrel (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

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: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized Enbrel in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 3.]

2. Has the patient had at least a 20% improvement in symptoms? Y N

   [No further questions.]

3. Does the patient have a diagnosis of rheumatoid arthritis (RA) with moderate to high disease activity? Y N

   [If no, skip to question 6.]

4. Has the patient had failure to an adequate trial (3 months) of two disease modifying anti-rheumatic drugs (DMARDs) regimens (one must be methotrexate)? Y N

   If yes, list medications tried: _____

   Note: Monotherapy regimen: methotrexate (MTX), hydroxychloroquine (HCQ), leflunomide (LEF), sulfasalazine (SSZ).

   Combination regimen: MTX+SSZ+HCQ; MTX+HCQ, MTX+LEF, MTX+SSZ, SSZ+HCQ

   [If yes, skip to question 38.]

5. Does the patient have a contraindication to methotrexate? Y N

   Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

   If yes, please document contraindication:_____

   [If no, then no further questions]

   [If yes, skip to question 38.]

6. Does the patient have a diagnosis of juvenile idiopathic arthritis (JIA)? Y N

   [If no, skip to question 18.]

7. Does the patient have the systemic subtype of JIA? Y N

   [If no, skip to question 11.]

8. Does the patient currently have any ACTIVE systemic features (? Y N

   Note: Systemic features such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis.

   If yes, please list:_____

   [If yes, then no further questions.]

9. Does the patient continue to have synovitis in at least 1 joint despite 3 months of treatment with methotrexate or leflunomide? Y N

   [If yes, skip to question 17.]

10. Does the patient have contraindications to methotrexate and Y N

leflunomide?

Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

If yes, please document contraindication:_____

[If no, then no further questions]

[If yes, skip to question 17.]

11. Does the patient have severe or moderate to severe polyarticular juvenile idiopathic arthritis (pJIA)? Y N

[If yes, skip to question 15.]

12. Does the patient have extended oligoarticular juvenile idiopathic arthritis (JIA)? Y N

[If no, then no further questions.]

13. Has the patient tried and had inadequate response with at least 2 different NSAIDs? Y N

If yes, please list medications tried:_____

[If yes, skip to question 15.]

14. Does the patient have intolerance or contraindications to NSAIDs? Y N

Note: Contraindications such as true allergic reaction to NSAIDs, history of worsening asthma symptoms after taking aspirin or NSAIDs, current GI bleed, severe renal dysfunction.

If yes, please document contraindication:_____

[If no, then no further questions]

15. Has the patient had failure to an adequate trial (3 months) of methotrexate? Y N

[If yes, skip to question 17.]

16. Does the patient have a contraindication to methotrexate? Y N

Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

If yes, please document contraindication:_____

[If no, then no further questions]

17. Is the patient at least 2 years of age? Y N

[If yes, skip to question 39.]

[If no, then no further questions]

18. Does the patient have a diagnosis of ankylosing spondylitis (AS)? Y N

[If no, skip to question 22.]

19. Does the patient have unacceptable disease activity despite an adequate trial (3 months) with at least 2 different NSAIDs? Y N

If yes, please list medications tried:_____

[If no, skip to question 21.]

20. Is the patient currently on or will continue taking an NSAID with the requested medication? Y N

[If yes, skip to question 38.]

21. Does the patient have contraindications to NSAIDs? Y N

Note: Contraindications such as true allergic reaction to NSAIDs, history of worsening asthma symptoms after taking aspirin or NSAIDs, current GI bleed, severe renal dysfunction.

If yes, please document contraindication:_____

[If yes, then skip to question 38.]

[If no, then no further questions]

22. Does the patient have a diagnosis of plaque psoriasis? Y N

[If no, skip to question 29.]

23. Does the patient have more than 10% of body surface area involvement with plaque psoriasis or has a PASI score of more than 10? Y N

[If no, then no further question.]

24. Does the plaque psoriasis have a significant impact on physical, psychological, or social wellbeing? Y N

[If no, then no further questions.]

25. Has the patient failed standard topical therapies? Y N

    List topical therapies tried:

    _____

    [If no, then no further questions.]

26. Has the patient tried and had an insufficient response to phototherapy (UVB or PUVA) or is unable to receive phototherapy? Y N

    If yes, please provide rationale:_____

    [If no, then no further questions.]

27. Has the patient had failure to an adequate trial (3 months) of methotrexate or cyclosporine? Y N

    [If yes, then skip to question 38.]

28. Does the patient have a contraindication to both methotrexate and cyclosporine? Y N

    Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

    If yes, please document contraindications:

    _____

    [If yes, then skip to question 38.]

    [If no, then no further questions.]

29. Does the patient have a diagnosis of psoriatic arthritis (PsA)? Y N

    [If no, then no further questions.]

30. Does the patient have primarily axial disease (involving the spine) or active enthesitis/dactylitis? Y N

    [If no, skip to question 32.]

31. Has the patient tried an adequate trial (3 months) with at least 2 different NSAIDs and had inadequate response? Y N

    If yes, please list medications tried:_____

    [If yes, skip to question 36.]

    [If no, skip to question 37.]

32. Does the patient have active psoriatic arthritis? Y N

    [If no, then no further questions.]

33. Has the patient had failure to an adequate trial (3 months) of methotrexate? Y N

    [If yes, skip to question 36.]

34. Does the patient have a contraindication to methotrexate? Y N

    Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

    If yes, please document contraindication:_____

    [If no, then no further questions]

35. Has the patient had failure to an adequate trial (3 months) of sulfasalazine or leflunomide? Y N

    [If no, then no further questions.]

36. Is the patient currently on or will continue taking an NSAID with requested medication? Y N

    [If yes, then skip to question 38.]

37. Does the patient have contraindications to NSAIDs? Y N

    Note: Contraindications such as true allergic reaction to NSAIDs, history of worsening asthma symptoms after taking aspirin or NSAIDs, current GI bleed, severe renal dysfunction.

    If yes, please document contraindication:_____

    [If no, then no further questions.]

38. Is the patient at least 18 years of age? Y N

    [If no, then no further questions.]

39. Is Enbrel being prescribed by, or in consultation with a specialist, based on indication (rheumatologist or dermatologist)? Y N

    List specialty: _____

    [If no, then no further questions.]

40. Has the patient been screened for latent tuberculosis (TB) and Y N

hepatitis B?

[If no, then no further questions.]

41. Does the patient have an active infection (including Hepatitis B and/or tuberculosis (TB)? Y N

[If no, skip to question 43.]

42. Is the patient currently receiving or has completed treatment for latent TB infection or Hepatitis B? Y N

[If no, then no further questions.]

43. Will Enbrel be given in combination with another biologic DMARD? Y N

[If yes, then no further questions.]

44. Does the patient have CHF (NYHA class III or IV)? Y N

Comments:

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

Prescriber (Or Authorized) Signature Date