Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Enbrel (etanercept) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Enbrel (etanercept).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a Rheumatologist or Dermatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

Rheumatology:

1. Member has diagnosis of psoriatic arthritis,
   □ No □ Yes

2. **AND** history of inadequate response, contraindication or intolerance to one or more medications to treat psoriatic arthritis such as conventional DMARDs (e.g. methotrexate or leflunomide) after a 3-month trial,
   □ No □ Yes

3. **AND** inadequate response, contraindication or intolerance to an infliximab product and adalimumab product [Amjevita (preferred), Humira] after a 3-month trial,
   □ No □ Yes

4. **AND** inadequate response, contraindication or intolerance to Cosentyx (secukinumab),
   □ No □ Yes

--OR--

1. Member has a diagnosis of active ankylosing spondylitis or nonradiographic axial spondyloarthritis
   □ No □ Yes

2. **AND** inadequate response, contraindication or intolerance to infliximab product [Inflectra (preferred), Remicade] and adalimumab product [Amjevita (preferred), Humira],
   □ No □ Yes

3. **AND** inadequate response, contraindication, or intolerance to full anti-inflammatory dose of an NSAID taken on a regular continuing basis for at least 4 weeks,
   □ No □ Yes

4. **OR** member has documented presence of enthesitis/tendonitis as part of manifestation of peripheral spondyloarthritis
   □ No □ Yes

--OR--

1. Member has diagnosis of peripheral spondylarthritis and does not have enthesitis/tendonitis,
   □ No □ Yes

2. **AND** history of inadequate response after 3-month trial, contraindication, or intolerance to at least one nonbiologic DMARD such as sulfasalazine, methotrexate or leflunomide,
   □ No □ Yes

3. **AND** inadequate response, contraindication, or intolerance to adalimumab product [Amjevita (preferred), Humira],
   □ No □ Yes

--OR--

1. Member has diagnosis of rheumatoid arthritis,
   □ No □ Yes

2. **AND** inadequate response, contraindication or intolerance to a 3-month minimum trial of one of the following: oral/subcutaneous methotrexate, hydroxychloroquine, leflunomide or sulfasalazine,
   □ No □ Yes

3. **AND** inadequate response, contraindication, or intolerance to infliximab product [Inflectra (preferred), Remicade] and adalimumab product [Amjevita (preferred), Humira] after at least a 3 month trial

□ No □ Yes

--OR--

1. Member is a pediatric patient ≥2 years with juvenile idiopathic arthritis who has failed methotrexate,
   □ No □ Yes

2. **AND** inadequate response, contraindication, or intolerance to adalimumab product [Amjevita (preferred), Humira],
   □ No □ Yes

Dermatology:

1. Member has a diagnosis of moderate to severe plaque psoriasis (>3% body surface area, unless palmar-plantar involvement is severe),
   □ No □ Yes

2. **AND** inadequate response or contraindication to at least a 3-month trial of phototherapy unless involvement in sensitive areas (e.g., face, body folds, etc.),
   □ No □ Yes

3. **AND** failed at least a 1-month trial of high or ultra-high potency topical corticosteroids, unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment,
   □ No □ Yes

4. **AND** failed at least a 3-month trial of **1 of the following** unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment:
   a. Methotrexate
   b. Acitretin
   □ No □ Yes

5. **AND** inadequate response, intolerance or contraindication to adalimumab product [Amjevita (preferred), Humira],
   □ No □ Yes

6. **AND** inadequate response, intolerance or contraindication to Cosentyx (secukinumab)
   □ No □ Yes

--OR--

1. Member is pediatric patient ≤17 years with diagnosis of moderate to severe plaque psoriasis and has contraindication, intolerance or inadequate response to topical psoriasis treatment,
   □ No □ Yes

2. **AND** inadequate response, intolerance, or contraindication to methotrexate or 12-week trial of phototherapy
   □ No □ Yes

Other Indications:

1. Treatment of Mediterranean fever, familial (FMF) if intolerance to colchicine AND prescribed by a specialist
   □ No □ Yes

2. **OR** adjunct treatment of Kawasaki disease if prescribed by a specialist
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member has positive clinical response to medication (i.e. asymptomatic or in clinical remission),
   □ No □ Yes

2. **AND** specialist follow-up occurred since last review
   □ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**