

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).** <u>Please complete all sections, incomplete forms will delay processing.</u> Fax this form back to Kaiser Permanente within 24 hours fax: <u>1-866-331-2104</u>. If you have any questions or concerns, please call <u>1-866-331-2103</u>. **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 Rheumato	logist 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					
	nulation:				
Sig:					
Drug 2: Name/Strength/Forn	nulation:				
5– Diagnosis/Clinical Criteria					
Is this request for initial o □ Initial therapy	or continuing therapy? □ Continuing therapy, State date:				
2. Indicate the patient's dia	gnosis for the requested medication:				

Cli	nical Criteria:
	<u>eumatology:</u>
lf t	reating psoriatic arthritis:
1.	Does the patient have a diagnosis of psoriatic arthritis?
	□ No □ Yes
2.	Does the patient have a history of inadequate response after a 3-month trial, contraindication or intolerance to ALL of the following?
	 At least one of the conventional DMARDs (e.g., methotrexate or leflunomide) Infliximab product (Inflectra preferred)
	Adalimumab product (Amjevita preferred)
	Cosentyx (secukinumab),
	□ No □ Yes
lf t	reating spondyloarthropathy/spondyloarthritis:
1.	Has the patient had an inadequate response after at least a 3-month trial, contraindication or intolerance to TWO of the following: infliximab product (Inflectra preferred), adalimumab product (Amjevita preferred), Xeljanz (tofacitinib)? □ No □ Yes
2.	Does the patient meet at least ONE of the following?
	 Diagnosis of active ankylosing spondylitis or nonradiographic axial spondyloarthritis, AND has inadequate response, contraindication, or intolerance to full anti-inflammatory dose of an NSAID taken on a regular continuing basis for at least 4 weeks
	 Presence of enthesitis/tendinitis as part of manifestation of peripheral spondyloarthritis such as Achilles tendinopathy or plantar fasciitis
	 Diagnosis of peripheral spondyloarthritis (i.e. reactive arthritis, spondyloarthritis related to inflammatory bowel disease or other peripheral spondyloarthritis rather than axial), does NOT have enthesitis, AND has had inadequate response after a 3-month trial, contraindication, or intolerance to at least one nonbiologic DMARD such as sulfasalazine, methotrexate, or leflunomide No
lf t	reating rheumatoid arthritis:
1.	Does the patient have a diagnosis of rheumatoid arthritis? □ No □ Yes
2.	Has the patient had an inadequate response after at least a 3-month trial, contraindication or intolerance to one of the following: oral/subcutaneous methotrexate, hydroxychloroquine, leflunomide or sulfasalazine? □ No □ Yes
3.	Does the patient have history of inadequate response after at least a 3-month trial, contraindication, or intolerance to infliximab product [Inflectra (preferred)] and adalimumab product [Amjevita (preferred)]?
lf t	reating juvenile idiopathic arthritis:
1.	Is the patient a pediatric patient ≥2 years with juvenile idiopathic arthritis who has failed methotrexate? □ No □ Yes
2.	Does the patient have history of inadequate response, contraindication, or intolerance to adalimumab product [Amievita (preferred)]?

□ No □ Yes

	<u>matology:</u>
	reating plaque psoriasis in adults ≥18 years of age:
1.	Does the patient have a diagnosis of moderate to severe plaque psoriasis (>3% body surface area, unless palmar-plantar involvement is severe)?
	□ No □ Yes
2.	Has the patient had an inadequate response after a 3-month trial, contraindication, or intolerance to phototherapy
	unless involvement in sensitive areas (e.g., face, body folds, etc.)?
	□ No □ Yes
3.	Has the patient 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
1	Has the patient failed at least a 3-month trial of ALL of the following unless clinically significant adverse effects,
٦.	contraindication or clinical reason to avoid treatment:
	a. Methotrexate or acitretin
	b. Adalimumab product (Amjevita preferred)
	c. Cosentyx (secukinumab)
	□ No □ Yes
	reating plaque psoriasis in pediatrics <18 years of age:
1.	Does the patient have a diagnosis of moderate to severe plaque psoriasis, and contraindication, intolerance or
	inadequate response to topical psoriasis treatment?
	□ No □ Yes
2.	Has the patient had an inadequate response, intolerance, or contraindication to methotrexate or at least a 12-week trial
	of phototherapy?
	□ No □ Yes
	reating other indications:
1.	Is the medication being used for treatment of Mediterranean fever, familial (FMF), with patient intolerance to colchicine
	AND prescribed by a specialist?
	□ No □ Yes
2.	OR is the medication being used for adjunct treatment of Kawasaki disease AND prescribed by a specialist?
	□ No □ Yes
	continuation of therapy, please respond to <u>additional questions</u> below:
1.	Has the patient had positive clinical response to medication (i.e. asymptomatic or in clinical remission)?
	□ No □ Yes
2	Has specialist follow-up occurred since last review?
۷.	□ 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:

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		,			
I certify that the information provided is accurate. Supporting documentation is available for State audits.					
Provider Signature:	Date:				
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