

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
ENBREL (entercept)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext.and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

Diagnosis _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

TO: 801-536-0477

CRITERIA:

Rheumatoid Arthritis or Psoriatic Arthritis

- ▶ Age requirement: 18 years old and older
- ▶ Diagnosis of moderate to severe Rheumatoid Arthritis or Psoriatic Arthritis
- ▶ History of treatment, incomplete response or intolerance to Methotrexate, or one other DMARD or second line drug (azathioprine, sulphadiazine, leflunomide, penicillamine, hydroxychloroquine, etc.)
- ▶ The number of swollen joints, must be 6 or more **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- ▶ The number of tender joints must be 9 or more **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- ▶ Negative TB skin test or history of treatment for latent TB infection
- ▶ Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition
- ▶ Rheumatology consultation within the last 60 days.
- ▶ Enbrel may not be given with other biologic agents such as Interferon, experimental medications or combination.

Ankylosing Spondylitis

- ▶ Diagnosis of Ankylosing Spondylitis
- ▶ Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- ▶ Negative TB skin test or history of treatment for latent TB infection
- ▶ Rheumatology consultation within the last 60 days.
- ▶ Enbrel may not be given with other biologic agents such as Interferon, experimental medications, or combinations.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance on medication.

7/10/08