

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM  
**ENBREL** (entercept) for **PLAQUE PSORIASIS**

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_

Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_

Phone#: \_\_\_\_\_ Ext. and options \_\_\_\_\_ Fax# \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

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

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF  
MEDICAL NECESSITY TO: 801-536-0477**

**CRITERIA:**

- ▶ Age requirement: 18 years old and older
- ▶ Diagnosis of moderate to severe Plaque Psoriasis
- ▶ History of incomplete response or intolerance to one appropriate systemic agent or photo therapy.
- ▶ Negative TB skin test or history of treatment for latent TB infection
- ▶ Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- ▶ Dermatology 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 with medication