



Prescription Drug Coverage Determination Form
Tumor Necrosis Factor Inhibitor
Enbrel® (etanercept)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-647-2240.

Patient Information

Patient Name: Date of Birth:
Subscriber ID#:
Address City State Zip Code

Physician Information

Name: Specialty: Tax ID#:
Office Address City State Zip Code
Telephone: Fax: Contact Person

Physician Signature (REQUIRED): Date

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: J-code:
Dose: Directions:
Expected Duration of Therapy:

Prior Authorization Criteria:

- 1. Does the patient have the diagnosis of moderately to severely active polyarticular (with multiple joint involvement) juvenile rheumatoid arthritis?
If yes:
- Has the patient had an inadequate response to at least 1 disease-modifying anti-rheumatic drug (DMARD) or has an intolerance to or contraindication to multiple DMARD drugs...
2. Does the patient have the diagnosis of moderately to severely active rheumatoid arthritis?
3. Does the patient have a diagnosis of active psoriatic arthritis?
4. Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis?
If yes:
- Is the patient 18 years of age or older?
- Is the patient a candidate for systemic therapy or phototherapy?
5. Does the patient have a diagnosis of active ankylosing spondylitis?

If yes:		
▪ Has the patient demonstrated an inadequate response to at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), or has intolerance or contraindication to multiple NSAIDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Does the patient have ankylosing spondylitis which is predominately peripheral arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Did the patient have an inadequate response, intolerance to, or has a contraindication to sulfasalazine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the patient have a diagnosis of active reactive arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Has the patient had an inadequate response, intolerance to, or contraindication to at least 2 NSAIDs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ If indicated, did the patient have an inadequate response to intra-articular steroid injections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ If indicated, did the patient have an inadequate response, intolerance to, or contraindication to sulfasalazine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does the patient have a diagnosis of chronic inflammatory bowel disease arthritis (IBDA)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Has the patient been refractory to standard therapies for IBDA (e.g. NSAIDs, sulfasalazine, azathioprine), or are standard therapies contraindicated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Has the patient been evaluated for latent tuberculosis with a PPD tuberculin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Did the patient have a positive PPD tuberculin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ If positive, is the patient being treated for latent tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Does the patient have an active infection, including chronic and localized infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Is the patient receiving a biologic response modifier, either a tumor necrosis factor (TNF) blocking agent [e.g., Humira, Remicade] or an interleukin-1 receptor antagonist (IL1-Ra) [e.g., Kineret] other than Enbrel?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Will the biologic response modifier be discontinued?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Has the patient been assessed for risk of active hepatitis B infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.