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:

If treating 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

If treating 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 □ Yes

If treating 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)]?
   □ No □ Yes

If treating 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 [Amjevita (preferred)]?
   □ No □ Yes

Dermatology:

If treating 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

4. Has the patient failed at least a 3-month trial of **ALL of the following** unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment:
   a. Methotrexate or acitretin
   b. Adalimumab product (Amjevita preferred)
   c. Cosentyx (secukinumab)
   □ No □ Yes

If treating 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

If treating 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

For continuation of therapy, please respond to additional questions 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?
   □ 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:**

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