



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Enbrel Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Enbrel**. 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.

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 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____ Prescriber 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: _____

Note: In order for the prior authorization to be approved, therapy requested must be for an FDA approved indication for patients age.

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: _____
3. Indicate patient's age _____

6 – Prescriber Sign-Off

Additional Information –

1. Please submit chart notes/medical records for the patient that are applicable to this request.

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:

Date:

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility