



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:
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