

US Family Health Plan Enbrel (Etanercept) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program (USFHP).

SPECIAL NOTES: Enbrel and Kineret are non-formulary (Tier 3) under the DoD Uniform Formulary and carry a higher copay for non-Active duty beneficiaries than Humira, Raptiva, and Amevive, which are formulary (Tier 2). US Family Health Plan does not cover Enbrel for Active duty beneficiaries, who pay no co-pay, unless it is determined to be medically necessary instead of a formulary agent. Medical necessity forms are available on the US Family Health Plan Pharmacy website at http://www.usfamilyhealth.org/f-downloadable_forms.html This form may NOT be used to meet medical necessity requirements.

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> The completed form and the prescription may be faxed to 1-617-562-5296 OR The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 		<ul style="list-style-type: none"> The provider may call: 1-877-880-7007 OR The completed form may be faxed to 1-617-562-5296

Prior authorization criteria and a copy of this form are available at: http://www.usfamilyhealth.org/f-downloadable_forms.html

Drug for which Prior Authorization is requested: Enbrel (etanercept)

Step 1 Please complete patient and physician information (Please Print)

1 Patient Name: _____ Physician Name: _____
 Address: _____ Address: _____
 Sponsor ID: _____ Phone #: _____
 Date of Birth: _____ Secure Fax: _____

Step 2 Please complete the clinical assessment:

2

1. Is this a continuation of therapy with Enbrel?	<input type="checkbox"/> Yes Please sign and date. See quantity limits below.	<input type="checkbox"/> No Proceed to Question 2
2. Will the patient be receiving Humira (adalimumab), Kineret (anakinra), or Remicade (infliximab) in combination with etanercept?	<input type="checkbox"/> Yes Coverage not approved.	<input type="checkbox"/> No Proceed to Question 3
3. Is Enbrel being prescribed for juvenile idiopathic arthritis?	<input type="checkbox"/> Yes Please sign and date. See quantity limits below.	<input type="checkbox"/> No Proceed to Question 4
4. Is Enbrel being prescribed for the treatment of moderately to severely active rheumatoid arthritis, the treatment of active psoriatic arthritis, or the treatment of ankylosing spondylitis?	<input type="checkbox"/> Yes Please sign and date. See quantity limits below.	<input type="checkbox"/> No Proceed to Question 5
5. Is Enbrel being prescribed for the treatment of chronic moderate to severe plaque psoriasis for which systemic therapy or phototherapy is indicated?	<input type="checkbox"/> Yes Please sign and date. See quantity limits below.	<input type="checkbox"/> No Coverage not approved

Step 3 I certify the above is correct and accurate to the best of my knowledge.

3 Please sign and date

Prescriber Signature

Date