PRIOR AUTHORIZATION FORM
Enbrel - Commercial/Medicaid

Unless otherwise indicated below, authorization quantities are limited to the manufacturer recommended dosage

SCRIPIUS
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P.O. Box 30192 Salt Lake City, UT 84130

Complete online at www.selecthealth.org/pa or fax back to: 801-442-3006
For questions or clarifications, call: 800-442-3129

Patient Information	
Patient's Name:	Patient's Date of Birth:
Patient's ID:	Patient's Phone #:
Diagnosis Code(s):	
Requesting Provider Information	
Name:	Phone #:
NPI/DEA:	Fax #:
Address:	Supervising Physician (if requesting provider bills under a different provider)
	Name:
	NPI/DEA:
Servicing Provider Information (if different than requesting provider)	
Name of provider or facility:	Phone number:
NPI/DEA:	Address:

Drug Name and Strength:	Directions / SIG:

Q1. Is this a reauthorization request?

☐ Yes ☐ No

Q2. What is the maintenance dosing requested?

☐ 50 mg or less once weekly
☐ 25 mg twice weekly
☐ Other

Q3. If requesting Other maintenance dosing, please specify:

Q4. What is the patient's diagnosis?

☐ Ankylosing Spondylitis (AS)
☐ Plaque Psoriasis (PsO)
☐ Polyarticular Juvenile Idiopathic Arthritis (JIA))
☐ Psoriatic Arthritis (PsA)

☐ Rheumatoid Arthritis (RA)
☐ Other

Q5. If other, please specify:

Q6. If other, chart notes are required for the request of this medication. Failure to provide chart notes will result in a delay in decision and/or denial. Did you attach relevant chart notes?

☐ Yes ☐ No

Q7. For plaque psoriasis, has the patient been diagnosed with chronic plaque psoriasis involving greater than or equal to 10 percent body surface area?

☐ Yes ☐ No

Q8. If less than 10 percent of the body is involved, is there scalp, palmar, foot, or groin involvement causing significant disability?

☐ Yes ☐ No

Q9. Has the patient failed greater than or equal to 12 weeks of methotrexate, cyclosporine, or acitretin therapy?

☐ Yes ☐ No

Q10. For RA, PsA, JIA, does the patient have persistent active disease treated for three months (less, if therapy discontinued due to complications) with at least one of the following treatments?

☐ Methotrexate
☐ Leflunomide
☐ Hydroxychloroquine
☐ Sulfasalazine
☐ Injectable gold salts
☐ Oral gold
☐ Azathioprine
☐ D-penicillamine
☐ Cyclosporine
☐ None of the above

Q11. Does the patient's treatment plan contain combination therapy with another biologic medication, JAK inhibitor or Otezla?

☐ Yes ☐ No

Q12. Additional comments

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

Prescriber Signature

Date