

**PRIOR AUTHORIZATION FORM**  
Enbrel - Commercial/Medicaid

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



a service of selecthealth.

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

Complete online at [www.selecthealth.org/pa](http://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:
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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?

- |  |  |
|--|--|
| <input type="checkbox"/> Methotrexate          | <input type="checkbox"/> Oral gold         |
| <input type="checkbox"/> Leflunomide           | <input type="checkbox"/> Azathioprine      |
| <input type="checkbox"/> Hydroxychloroquine    | <input type="checkbox"/> D-penicillamine   |
| <input type="checkbox"/> Sulfasalazine         | <input type="checkbox"/> Cyclosporine      |
| <input type="checkbox"/> Injectable gold salts | <input type="checkbox"/> 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

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