Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Enbrel - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have the diagnosis of rheumatoid arthritis or psoriatic arthritis?
If No, go to 4.

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Has the patient failed or had an inadequate response to the trial of at least one or more disease modifying antirheumatic drug (DMARD) OR is intolerant to DMARDs (e.g., azathioprine, hydroxychloroquine, D-penicillamine, sulfasalazine, methotrexate and non-steroidal anti-inflammatory drugs [NSAIDs])?
If Yes, go to 15.

☐ Yes ☐ No

Q4. Does the patient have the diagnosis of plaque psoriasis?
If No, go to 9.

☐ Yes ☐ No

Q5. Is the patient 4 years of age or older?

☐ Yes ☐ No

Q6. Is the disease moderate to severe?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q7. Is there documentation of inadequate response, intolerance or contraindication to methotrexate OR ultraviolet-B (UVB) therapy (alone or in combination with other medications) OR acitretin (requires prior authorization)?
If Yes, go to 16.

☐ Yes ☐ No

Q8. Is there documentation of inadequate response, intolerance or contraindication to one topical steroid (high to very high potency) AND calcipotriene 0.005% cream?

☐ Yes ☐ No

Q9. Does the patient have the diagnosis of polyarticular juvenile idiopathic arthritis (JIA)?
If No, go to 12.

☐ Yes ☐ No

Q10. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q11. Is there documentation of inadequate response, intolerance or contraindication toone or more disease modifying anti-rheumatic drug (DMARD) OR is intolerant to DMARDS (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], sulfasalazine, methotrexate, azathioprine, cyclosporine, or prednisone)?
If Yes, go to 15.

☐ Yes ☐ No

Q12. Does the patient have the diagnosis of ankylosing spondylitis?

☐ Yes ☐ No

Q13. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q14. Is there documentation of inadequate response, intolerance or contraindication to at least two or more non-steroidal anti-inflammatory drugs (NSAIDs) OR is intolerant to NSAIDs?

☐ Yes ☐ No

Q15. Is Enbrel being prescribed by, or in consultation with, a rheumatologist?

☐ Yes ☐ No

Q16. Is Enbrel being prescribed by, or in consultation with, a dermatologist?

☐ Yes ☐ No

Q17. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q18. Was the tuberculin skin test negative?

☐ Yes ☐ No

Q19. Has the patient received appropriate prophylaxis in accordance with Centers for Disease Control and Prevention (CDC) guidelines?

☐ Yes ☐ No

Q20. Additional Information:

Q21. Requested Duration:

☐ 12 Months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request

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