



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Enbrel® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information (required)					
<b>Continuation of therapy:</b> Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: <b>(REQUIRED)</b> _____ _____					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Active ankylosing spondylitis <input type="checkbox"/> Active psoriatic arthritis <input type="checkbox"/> Moderate to severe plaque psoriasis <input type="checkbox"/> Moderately to severely active polyarticular juvenile idiopathic arthritis <input type="checkbox"/> Moderately to severely active rheumatoid arthritis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Prescriber's Specialty:</b> Is Enbrel prescribed by a rheumatologist, dermatologist, or gastroenterologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Clinical Information:</b> Will the provider submit a statement or chart notes documenting patient has had a failure of methotrexate and one other disease-modifying antirheumatic drug (DMARD) (mesalamine may be considered a DMARD)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there presence of contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>For plaque psoriasis:</b> Will the provider submit a statement or chart notes documenting patient has had a failure of topical steroids and PUVA? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b> <b>If this is a reauthorization request, answer the following question:</b> Does the patient show symptom reduction from baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Enbrel\_GoldCoast\_2019Aug1-W



## Enbrel® Prior Authorization Request Form (Page 2 of 2)

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### Quantity Limit Requests:

What is the quantity requested per DAY? \_\_\_\_\_

### What is the reason for exceeding the plan limitations?

- Titration or loading dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- Other: \_\_\_\_\_

### For continuation of existing therapy, also answer the following:

Would sudden discontinuation of the dose trigger withdrawal symptoms?  Yes  No

Would discontinuation of the dose be unsafe for the patient and their condition may worsen or exacerbate?  Yes  No

Is the prescribing provider attempting to taper or reduce the dose necessary?  Yes  No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note:

This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-800-527-0531.