

Health New England
Medication Request Form (MRF)/Prescription Request
Enbrel™ (etanercept)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Enbrel®. Please complete this form and fax to ICORE Healthcare at (866) 364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

J-code = J1438, 1 unit = 25mg (if administered in physicians office only, not self administration)

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
	Specialty:
Patient Cell Phone #: () -	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Telephone #: () -
Diagnosis:	Fax #: () -

Drug Information

Drug/Strength/Form: Enbrel <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> SureClick Auto Injector

Dose, Directions, and length of treatment (please be specific): 8 vials / month max (may have 50mg twice weekly x 3 months for psoriasis only)	Quantity (per month):	Refills:
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Physician Signature:	Date:
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Indication: <input type="checkbox"/> Moderate to Severe Rheumatoid Arthritis. <input type="checkbox"/> Polyarticular Juvenile Rheumatoid Arthritis. <input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Plaque Psoriasis <input type="checkbox"/> Diagnosis of Ankylosing Spondylitis <input type="checkbox"/> Other (please explain)	Severity <ul style="list-style-type: none"> • Body Surface Area Involvement (percent): _____% • PASI (Psoriasis Area and Severity Index) Score: _____(range 0 to 72)
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Documentation of Medical Necessity (check all that apply): <input type="checkbox"/> Enbrel is recommended by a Rheumatologist within the previous 12 months (required). <input type="checkbox"/> Request is for continuation of therapy <input type="checkbox"/> Patient is intolerant to or failed therapy of at least one (1) DMARD or immunomodulator (including methotrexate, sulfasalazine, hydroxychloroquine, aurothioglucose, auranofin, gold sodium thiomalate, azathioprine, d-penicillamine, cyclosporine, infliximab, leflunomide, or anakinra). <input type="checkbox"/> Active infections (i.e., histoplasmosis, cytomegalovirus, tuberculosis, local infection or HIV) have been excluded (required). <input type="checkbox"/> Patient does not have a history of recurrent infections or systemic malignancy. <input type="checkbox"/> Patient is not concurrently receiving other immunosuppressive agents (i.e., cyclosporine, methotrexate, alefacept, efalizumab, infliximab) or TNF agents such as (leflunomide, adalimumab, anakinra or infliximab), or abatacept. <input type="checkbox"/> Other pertinent history:
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Check other drugs/treatments tried or contraindicated (check all that apply): <input type="checkbox"/> PUVA <input type="checkbox"/> UVB <input type="checkbox"/> Acitretin <input type="checkbox"/> Methotrexate <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Other _____
