

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 Prefilled Syringe 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:** _____

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):

Enbrel is recommended by a Rheumatologist within the previous 12 months (required).

Request is for continuation of therapy

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).

Active infections (i.e., histoplasmosis, cytomegalovirus, tuberculosis, local infection or HIV) have been excluded (required).

Patient does not have a history of recurrent infections or systemic malignancy.

Patient is not concurrently receiving other immunosuppressive agents (i.e., cyclosporine, methotrexate, alefacept, efalizumab, infliximab) or TNF agents such as (leflunomide, adalimumab, anakinra infliximab, or certolizumab pegol), or abatacept.

Other pertinent history:

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 _____