BlueCross BlueShield Federal Employee Program

ENBREL
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Enbrel (etanercept)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑**25mg** **OR** ❑**50mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 4**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
4. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*
   If POSITIVE, has the patient completed treated or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
5. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑No
   If YES, has HBV infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No
6. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
7. Will Enbrel be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
8. What is the patient's diagnosis?
   ❑Ankylosing Spondylitis (AS)
   a. Does the patient have active ankylosing spondylitis? ❑Yes ❑No
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No
   c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No
   d. **Standard/Basic Option, for claims adjudicated through the pharmacy benefit:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Simponi, or Xeljanz/Xeljanz XR? ❑Yes* ❑No
      If YES, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Simponi ❑Xeljanz/Xeljanz XR

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Plaque Psoriasis (PsO)

a. Does the patient have chronic moderate to severe plaque psoriasis? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***

❑ Inadequate response ❑ Intolerance or contraindication ❑ Has not tried conventional systemic therapy

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy? ***Please select answer below:***

❑ Inadequate response ❑ Intolerance or contraindication ❑ Has not tried phototherapy

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Ilumya, Siliq, or Sotyktu? ❑Yes***** ❑No

****If YES***, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Ilumya ❑Siliq ❑Sotyktu

e. **Age 4-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 63kg (138lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.8 milligrams per kilogram (mg/kg) weekly? ❑Yes ❑No

❑**63kg (138lbs) or more**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

f. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

❑ Polyarticular Juvenile Idiopathic Arthritis (pJIA)

a. Does the patient have moderately to severely active polyarticular course juvenile idiopathic arthritis? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3 month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from Actemra SC or an Actemra SC biosimilar, Cimzia, or Orencia SC to allow the member access to their copay benefit? ❑Yes***** ❑No

****If YES***, please select medication: ❑Actemra SC/Actemra SC biosimilar ❑Cimzia ❑Orencia SC

d. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 63kg (138lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.8 milligrams per kilogram (mg/kg) weekly? ❑Yes ❑No

❑**63kg (138lbs) or more**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

e. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

❑ Juvenile Psoriatic Arthritis (JPsA)

a. Does the patient have active juvenile psoriatic arthritis? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3 month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. **Age 2-17**: What is the patient's weight? ***Please select answer below***:

❑**Less than 63kg (138lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.8 milligrams per kilogram (mg/kg) weekly? ❑Yes ❑No

❑**63kg (138lbs) or more**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

d. **Age 18 or older:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

PLEASE PROCEED TO <u>PAGE 3</u> FOR ADDITIONAL DIAGNOSES

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PAGE 3 – PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑ Psoriatic Arthritis (PsA)

a. Does the patient have active psoriatic arthritis? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3 month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Orencia SC or Simponi? ❑Yes***** ❑No

****If YES***, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Orencia SC ❑Simponi

❑ Rheumatoid Arthritis (RA)

a. Does the patient have moderate to severely active rheumatoid arthritis? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3 month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Actemra SC or an Actemra SC biosimilar, Cimzia, Kevzara, Kineret, Olumiant, Orencia SC, or Simponi?
❑Yes***** ***(*If YES, please select the medication below)*** ❑No

❑Actemra SC/Actemra SC biosimilar ❑Cimzia ❑Kevzara ❑Kineret ❑Olumiant ❑Orencia SC ❑Simponi

❑ Other ***(please specify)***: _____

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Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)
Enbrel (etanercept)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑**25mg** **OR** ❑**50mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. Has the patient's condition improved or stabilized with Enbrel or biosimilar therapy? ❑Yes ❑No

4. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No

5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

6. Will Enbrel be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR

7. What is the patient's diagnosis?
   ❑Ankylosing Spondylitis (AS)
      a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No
   ❑Plaque Psoriasis (PsO)
      a. **Age 4-17**: What is the patient's weight? ***Please select answer below:***
         ❑**Less than 63kg (138lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.8 milligrams per kilogram (mg/kg) weekly? ❑Yes ❑No
         ❑**63kg (138lbs) or more**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No
      b. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

PLEASE PROCEED TO PAGE 5 FOR ADDITIONAL DIAGNOSES

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PAGE 5 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Polyarticular Juvenile Idiopathic Arthritis (pJIA)

a. **Age 2-17:** What is the patient's weight? ***Please select answer below:***

❑**Less than 63kg (138lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.8 milligrams per kilogram (mg/kg) weekly? ❑Yes ❑No

❑**63kg (138lbs) or more**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

b. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

❑Juvenile Psoriatic Arthritis (JPsA)

a. **Age 2-17**: What is the patient's weight? ***Please select answer below***:

❑**Less than 63kg (138lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.8 milligrams per kilogram (mg/kg) weekly? ❑Yes ❑No

❑**63kg (138lbs) or more**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

b. **Age 18 or older:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

❑ Psoriatic Arthritis (PsA)

a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

❑ Rheumatoid Arthritis (RA)

a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50mg weekly? ❑Yes ❑No

❑ Other ***(please specify)***: _____