



**Enbrel  
(etanercept)**

**Prior Authorization Form  
Curascript  
Fax (888) 773-7386**

Last Name		First Name		Prescriber's Name		Specialty	
Home Phone		Work Phone		Office Phone		Office Fax	
Home Address		City	State	ZIP	Address		City State ZIP
SCAN ID number		Date of Birth		Est. Start Date		Office Contact	
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home				Special Instructions (i.e. Non-English Speaking Patient, etc.):			

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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<b>1. Has patient tried Humira for greater than one month with an inadequate response?</b>
<b>2. Will patient be receiving Humira, Kineret or Remicade in combination with Enbrel?</b>
<b>3. Is the diagnosis or indication for the treatment of moderately to severely active Rheumatoid Arthritis?</b> <b>If no continue to #5</b>
<b>4. Is the patient currently taking or has the patient tried and failed at least one Disease-Modifying Anti-Rheumatic Drug for the current condition (examples include methotrexate, leflunomide, azathioprine, cyclosporine, cyclophosphamide, hydroxychloroquine sulfate)?</b>
<b>5. Is the diagnosis or indication for the treatment of one of the following:</b> a. Psoriatic Arthritis b. Ankylosing Spondylitis c. Polyarticular-Course Juvenile Rheumatoid Arthritis <b>If no continue to #7</b>
<b>6. Is the patient currently taking or has the patient tried and failed methotrexate for the current condition?</b>
<b>7. Is the diagnosis or indication for Enbrel for the treatment of chronic moderate to severe plaque psoriasis?</b>
<b>8. Is the patient a candidate for phototherapy or systemic therapy</b>
<b>9. Has the patient tried and failed traditional therapy for psoriasis, such as phototherapy (e.g. UVB, PUVA) or systemic therapy (e.g. methotrexate, acitretin, cyclosporine)? If so, please specify.</b>
<b>10. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?</b>

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_