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	
VH ID number	Date of Birth	Est. Start Date	Office Contact
For Specialty Medications Only: Shipping Address (if different from home address) ☐ Physician ☐ 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

1.	**Will the patient be receiving Humira, Kineret or Remicade in combination with Enbrel?**
2.	**Is the diagnosis or indication for the treatment of Moderate to Severe Active Rheumatoid Arthritis? If No, continue to #4.**
3.	**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)? Please specify.**
4.	**Is the diagnosis or indication one of the following:** ❑ **Active Psoriatic Arthritis** ❑ **Ankyosing Spondylitis** ❑ **Polyarticular-Course Juvenile Rheumatoid Arthritis** **If No, continue to #6.**
5.	**Is the patient currently taking or has the patient tried and failed methotrexate? Please specify.**
6.	**Is the diagnosis or indication for Enbrel for the treatment of chronic moderate to severe plaque psoriasis?**
7.	**Is the patient a candidate for phototherapy or systemic therapy?**
8.	**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.**
9.	**Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?**

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

For Internal Use Only
☐ Approved ☐ Denied Reviewer's Initials _____ Decision Date _____
Comments_____

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.scanhealthplan.com.