UnitedHealthcare Community Plan

Enbrel
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
□ **Yes** □ **No**	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Moderately to severely active rheumatoid arthritis (RA) □ Moderately to severely active polyarticular juvenile idiopathic arthritis □ Active psoriatic arthritis □ Moderate to severe chronic plaque psoriasis □ Ankylosing spondylitis
□ **Yes** □ **No**	**Is Enbrel prescribed or recommended by one of the following?** *(If yes, check which applies)* □ Dermatologist □ Rheumatologist
□ **Yes** □ **No**	**Is the patient receiving Enbrel in combination with any of the following?** *(If yes, check which applies)* □ Biologic DMARD [e.g. Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)] □ Janus Kinase inhibitor [e.g. Xeljanz (tofacitinib)] □ Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]
	RHEUMATOID ARTHRITIS
□ **Yes** □ **No**	**Is there a history of failure, contraindication, or intolerance to any non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g. methotrexate, leflunomide, sulfasalazine, hydroxychloroquine]?** *(If yes, complete Section D above)*
	JUVENILE IDIOPATHIC ARTHRITIS
□ **Yes** □ **No**	**Is there a history of failure, contraindication, or intolerance to any of the following DMARDs?** *(If yes, check which applies and complete Section D above)* □ Leflunomide (Arava) □ Methotrexate (Rheumatrex/Trexall)
	ANKYLOSING SPONDYLITIS
□ **Yes** □ **No**	**Is there a history of failure, contraindication, or intolerance to two or more NSAIDs?** *(If yes, complete Section D above)*
	CONTINUATION OF THERAPY
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Enbrel therapy?** *If yes, list response:*

Physician Signature: _____ **Date:** _____