OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Enbrel® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Active ankylosing spondylitis
- ❑ Active psoriatic arthritis (PsA)
- ❑ Moderate to severe chronic plaque psoriasis
- ❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)
- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of prior Enbrel therapy? ❑ **Yes** ❑ **No**

Will the patient be receiving Enbrel in combination with a biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab pegol), Simponi (golimumab), Orencia (abatacept)]? ❑ **Yes** ❑ **No**

Select if Enbrel is prescribed by or in consultation with one of the following specialists:

❑ Dermatologist ❑ Rheumatologist

For active ankylosing spondylitis, also answer the following:

Has the patient had trial and failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be inappropriate:

❑ Cimzia (certolizumab pegol) ❑ Humira (adalimumab) ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

For active psoriatic arthritis (PsA), also answer the following:

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

❑ Cimzia (certolizumab pegol)
❑ Cosentyx (secukinumab)
❑ Humira (adalimumab)
❑ Simponi (golimumab) or Simponi Aria (golimumab IV)
❑ Stelara (ustekinumab)
❑ Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)

For moderate to severe chronic plaque psoriasis, also answer the following:

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

❑ Cimzia (certolizumab pegol)
❑ Cosentyx (secukinumab)
❑ Humira (adalimumab)
❑ Stelara (ustekinumab)
❑ Tremfya (guselkumab)

For moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA), also answer the following:

Has the patient had trial and failure, contraindication, or intolerance to one of the following non-biologic modifying anti-rheumatic drugs (DMARDs): Arava (lefunomide) **OR** Rheumatrex/Trexall (methotrexate)? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to Humira (adalimumab)? ❑ **Yes** ❑ **No**

Enbrel® Prior Authorization Request Form (Page 2 of 2)

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For moderately to severely active rheumatoid arthritis (RA), also answer the following:

Has the patient had trial and failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Rheumatrex/Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine)]? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be inappropriate:

❑ Cimzia (certolizumab pegol) ❑ Humira (adalimumab) ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

❑ Kevzara (sarilumab) ❑ Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to Enbrel therapy? ❑ **Yes** ❑ **No**

Is the patient receiving Enbrel in combination with a biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.