CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Enbrel**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:		
Provider First Name:		Provider Last Name:		
Provider Phone:		Provider Fax:	Provider NPI #:	
Patient Name:		CCHP Member ID Number:		Patient DOB:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:	Patient Age:

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	Yes ☐ No ☐
Diagnosis:			Date of diagnosis:

Please indicate place of administration?	☐ **Physician's Office** ☐ **Hospital/Facility**	Please indicate how medication will be billed: ☐ **Billed directly by the provider via JCODE Provide JCODE:_____** ☐ **Billed by a pharmacy and delivered to the provider** ☐ **Billed by a pharmacy and delivered to the patient**
Please provide facility/provider name and address:		

Please complete the following questions for *all* diagnoses.

Please indicate disease severity:	☐ Mild ☐ Moderate ☐ Severe
Is there evidence of Infection?	☐ Yes ☐ No
Date of PPD (tuberculin) test:	**Result of PPD test:** ☐ Positive ☐ Negative
Is the member currently using another TNF-blocking agent or biologic agent in combination with Enbrel? If yes, please indicate drug name:	☐ Yes ☐ No

Please indicate the diagnosis on the left and complete the corresponding questions.

Rheumatoid Arthritis **Juvenile Idiopathic Arthritis**	Has the member tried and failed Methotrexate for at least 3 months? Please provide dates of therapy and dose:	☐ Yes ☐ No
	Reason for discontinuation:	
	Please indicate if the member tried and failed any of the following for at least 3 months? ☐ **Leflunomide (Arava)** ☐ **Minocycline (Minocin)** ☐ **Sulfasalazine (Azulfidine)** ☐ **Hydroxychlorquine (Plaquenil)**	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
Psoriatic Arthritis	Does the member have dominant **peripheral** disease?	☐ Yes ☐ No
	Does the member have dominant **axial** disease?	☐ Yes ☐ No
	Please indicate if the member tried and failed any of the following for at least 3 months?	

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	☐ **Cyclosporine (Neoral, Sandimmune)** ☐ **Sulfasalazine (Azulfidine)** ☐ **Leflunomide (Arava)** ☐ **Methotrexate**	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
	Has the member tried and failed any NSAIDs for at least 3 months?	☐ Yes ☐ No
	Please indicate drug name(s):	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
Ankylosing Spondylitis	Does the member have dominant **peripheral** disease?	☐ Yes ☐ No
	Does the member have dominant **axial** disease?	☐ Yes ☐ No
	Please indicate if the member tried and failed any of the following for at least 3 months? ☐ **Methotrexate** ☐ **Sulfasalazine (Azulfidine)**	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
	Has the member tried and failed any NSAIDs for at least 3 months?	☐ Yes ☐ No
	Please indicate drug name(s) and dose:	
	Please provide dates of therapy:	
	Reason for discontinuation:	
Plaque Psoriasis	Please indicate body surface area (BSA) involvement: ☐ Less than 10% ☐ Greater than or equal to 10%	
	Does the member have psoriasis on the palms, soles, head, neck, or genitalia?	☐ Yes ☐ No
	Has the member tried and failed topical treatments?	☐ Yes ☐ No
	If yes, indicate drug name :	
	Reason for discontinuation:	
	Has the member tried and failed phototherapy or photochemotherapy	☐ Yes ☐ No
	Please indicate if the member tried and failed any of the following for at least 3 months? ☐ **Methotrexate** ☐ **Cyclosporine (Neoral, Sandimmune)** ☐ **Acitretin (Soriatane)**	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
Please provide any additional information which should be considered in the space below:		