Enbrel® (etanercept) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment ☐ Continuation of therapy, date of last treatment ____/____/____

Precertification Requested By: ______________________ Phone: ____________ Fax: ____________

A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:		City:		State:	ZIP:
Home Phone:	Work Phone:		Cell Phone:	Email:	
Current Weight: _______ lbs or _______ kgs Height: ______ inches or ______ cms			Allergies:		

B. INSURANCE INFORMATION

Aetna Member ID #: ______________________
Group #: ______________________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ____________ Carrier Name: ______________________
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: (Check One): ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Rheumatologist** ☐ **Dermatologist** ☐ **Other**: ______________________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ______________________
Center Name: ______________________
☐ Home Infusion Center Phone: ______________________
Agency Name: ______________________
☐ Administration code(s) (CPT): ______________________
Address: ______________________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other ______________
Name: ______________________
Address: ______________________
Phone: ______________ Fax: ______________
TIN: ______________ PIN: ______________

E. PRODUCT INFORMATION

Request is for Enbrel (etanercept): Dose: ______________ **Frequency:** ______________________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD code: ______________________ **Other**: ______________________

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For Initiation Requests (clinical documentation required):

☐ Yes ☐ No Will Enbrel (etanercept) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRAs) or chest x-ray within 6 months of initiation a biologic therapy?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter results of the TB test: ☐ positive ☐ negative ☐ unknown
If positive, Does the patient have latent or active TB? ☐ latent ☐ active
If latent TB, ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with Enbrel (etanercept)?

For Ankylosing spondylitis or Axial spondyloarthritis (an early form of ankylosing spondylitis)

Please select which of the following applies to the patient: ☐ Ankylosing spondylitis ☐ Axial spondyloarthritis

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Has the patient had an ineffective response to two or more non-steroidal anti-inflammatory drugs (NSAIDs)?
→ Please provide the names and length of treatment:
NSAID #1: ______________________
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
NSAID #2: ______________________
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

Behcet's Disease

☐ Yes ☐ No Is the disease refractory to both glucocorticoids and azathioprine?

Juvenile Idiopathic Arthritis (Juvenile Rheumatoid Arthritis)

Please indicate the severity of the patient's disease: ☐ mild ☐ moderate ☐ severe

☐ Yes ☐ No Is there evidence that the disease is active?

Plaque Psoriasis (Adult and Pediatric)

☐ Yes ☐ No Is there clinical documentation of chronic disease?
→ Please indicate the severity of the patient's plaque psoriasis: ☐ mild ☐ moderate ☐ severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Is the patient a candidate for systemic therapy or phototherapy?
→ Please select: ☐ phototherapy ☐ systemic therapy ☐ phototherapy and systemic therapy

Please provide the patient's Psoriasis Area and Severity Index (PASI) score: _____

Please indicate the percentage of body surface area affected by plaque psoriasis: _____%

☐ Yes ☐ No Does the plaque psoriasis affect sensitive areas? ***If yes***, please select: ☐ hands ☐ feet ☐ face ☐ genitals

Adult

☐ Yes ☐ No Was a trial of systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?
→ ☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) not tolerated?
☐ Yes ☐ No Are systemic conventional DMARD(s) contraindicated?
→ Please select: ☐ acitretin ☐ cyclosporine ☐ methotrexate ☐ mycophenolate ☐ Other, please explain: ____________________
Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was a trial with phototherapy ineffective?
→ ☐ Yes ☐ No Was the trial with phototherapy not tolerated?
☐ Yes ☐ No Is phototherapy contraindicated?
→ Please check all that apply:
☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
☐ UVB with coal tar or dithranol
☐ UVB (standard or narrow band)
☐ Home UVB
☐ None of the above
Please indicate the length of trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Pediatric

☐ Yes ☐ No Was a trial with phototherapy ineffective, not tolerated, or contraindicated?
→ Please check all that apply:
☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
☐ UVB with coal tar or dithranol
☐ UVB (standard or narrow band)
☐ Home UVB
☐ None of the above
Please indicate the length of trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Psoriatic Arthritis

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?
→ ☐ Yes ☐ No Was the treatment with two or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?
→ Please provide the names and length of treatment:
NSAID #1: ______________________________
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
NSAID #2: ______________________________
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?
→ ☐ Yes ☐ No Does the patient have severe disease at presentation, defined as severe disability at onset with erosive disease involving multiple joints?
→ ☐ Yes ☐ No Was the treatment with methotrexate ineffective?
→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?
→ Please select: ☐ not tolerated ☐ contraindicated
☐ Yes ☐ No Was treatment with another conventional DMARD ineffective?
→ Please select: ☐ cyclophosphamide ☐ cyclosporine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine ☐ Other, please explain: __________
Please indicate length of treatment:
☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
→ Indicate length of therapy: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

Reactive Arthritis (Reiter's syndrome)

☐ Yes ☐ No Was the treatment with methotrexate ineffective?
→ Please indicate length of therapy: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was the treatment with sulfasalazine ineffective?
→ Please indicate length of therapy: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was the treatment with non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?
→ Please provide the name: ______________________
Please indicate length of therapy: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was the treatment with steroids ineffective?
→ Please provide the name: ______________________
Please indicate length of therapy: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Rheumatoid Arthritis

Please indicate the severity of the patient's rheumatoid arthritis: ☐ mild ☐ moderate ☐ severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Was treatment with methotrexate ineffective?
→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated
→ ☐ Yes ☐ No Was treatment with another conventional DMARD (other than methotrexate) ineffective?
→ Please select: ☐ azathioprine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
→ Please indicate length of the methotrexate therapy: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

For Continuation of Therapy (clinical documentation required):

Please indicate the length of time on Enbrel (etanercept) therapy: ______________________

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Enbrel (etanercept)? (Sampling of Enbrel (etanercept) does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Will Enbrel (etanercept) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Does the patient have any risk factors for TB?
→ ☐ Yes ☐ No Has the patient had a TB test within the past year?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ positive ☐ negative ☐ unknown

For Juvenile idiopathic arthritis, Plaque psoriasis, and Rheumatoid arthritis only:

Please indicate the severity of the disease at baseline (pretreatment with Enbrel (etanercept)): ☐ mild ☐ moderate ☐ severe

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: ______________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.