05/30/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Enbrel (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Enbrel (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Enbrel (etanercept)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If no, skip to question 3.]

2. Is the patient responding to Enbrel therapy? Y N

   [No further questions.]

3. Initial Authorization: Rheumatoid Arthritis (RA) Does the patient have a diagnosis of moderate to severe rheumatoid arthritis? Y N

[If no, skip to question 6.]

4. Is the patient at least 18 years of age? Y N

   [If no, no further questions.]

5. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication to methotrexate and other DMARDs, list drugs and contraindications): Y N

   _____

   Failure of a 3-month compliant trial of methotrexate AND at least 1 other DMARD (e.g., sulfasalazine, hydroxychloroquine, or leflunomide) \ Documented contraindication to methotrexate and other DMARDs

   [No further questions.]

6. Initial Authorization: Juvenile Idiopathic Arthritis (JIA) Does the patient have a diagnosis of juvenile idiopathic arthritis? Y N

   [If no, skip to question 9.]

7. Is the patient at least 2 years of age? Y N

   [If no, no further questions.]

8. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication to methotrexate, list contraindication): Y N

   _____

   Trial and failure of at least 3 consecutive months of methotrexate \ Documented contraindication to use of methotrexate

   [No further questions.]

9. Initial Authorization: Ankylosing Spondylitis (AS) Does the patient have a diagnosis of ankylosing spondylitis? Y N

   [If no, skip to question 12.]

10. Is the patient at least 18 years of age? Y N

    [If no, no further questions.]

11. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication to NSAIDs, list contraindication): Y N

    _____

Trial and failure of two different NSAIDs (e.g., ibuprofen, naproxen, etodolac, meloxicam, indomethacin) within the last 60 days OR \ Documented contraindication to NSAIDs

[No further questions.]

12. Initial Authorization: Plaque Psoriasis. Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis? Y N

[If no, skip to question 16.]

13. Does the patient meet both of the following criteria? Y N

Patient is at least 4 years of age AND \ Prescribed dose of Enbrel does not exceed 50mg twice weekly

[If no, no further questions.]

14. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication to UVB and PUVA, list contraindication): Y N

_____

Trial and failure of UVB or PUVA,OR \ Documented contraindication to UVB and PUVA

[If no, no further questions.]

15. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication to methotrexate, list contraindication): Y N

_____

Trial and failure of methotrexate for at least 3 months \ Documented contraindication to use of methotrexate

16. Initial Authorization: Psoriatic Arthritis. Does the patient meet ALL of the following? Y N

Diagnosis is moderate to severe psoriatic arthritis \ Patient is 18 years of age or older

[If no, no further questions.]

17. Does the patient meet ONE of the following? Please indicate which of the above apply to patient (if patient has contraindication to methotrexate, list contraindication): Y N

_____

Trial and failure of a compliant regimen of methotrexate for at least 3 months \ Documented contraindication to use of methotrexate

[No further questions.]

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date