SENDERO HEALTH PLANS

Prior Authorization Request Form	**Enbrel**
Sendero Fax: 512-901-9724	**Phone:** 855-297-9191
URGENCY: ☐ **STANDARD**	☐ **URGENT (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health or ability to regain maximum function)**

Provider Information	**Patient Information**
Referring/Prescribing Physician: ☐ **PCP** ☐ **Specialist** **Name:** **Please identify SPECIALTY:** **DEA, NPI or TIN:** **Contact:** **Phone: ( ) Fax: ( )**	**Patient's Name:** **Birth Date:** **ID Number:** **Phone Number:** **Patient Height:** **Patient Weight:**
Indicate where the drug is being DISPENSED	**Indicate where the drug is being ADMINISTERED**
☐ **Ambulatory Surgery Center** ☐ **Home Care Agency** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):**	☐ **Ambulatory Surgery Center** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):** **Anticipated Date of Service:**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PATIENT CLINICAL INFORMATION

CRITERIA QUESTIONS:

1. Has the patient been diagnosed with any of the following?
   - ☐ Rheumatoid arthritis (RA)
   - ☐ Psoriasis
   - ☐ Psoriatic arthritis (PsA)
   - ☐ Ankylosing spondylitis (AS), or Peripheral/Axial spondyloarthritis (seronegative spondyloarthropathy)
   - ☐ Juvenile idiopathic arthritis (JIA) – polyarticular, oligoarticular, or systemic
   - ☐ Hidradenitis Suppurativa
   - ☐ Pyoderma gangrenosum
   - ☐ Behcet's Disease
   - ☐ Graft-versus-Host Disease (acute or chronic)
   - ☐ Other: _____
2. What is the HCPCS code? _____ What is the ICD-10 code? _____
   What is the NDC#: _____
3. Will the requested drug be used in combination with any other biologic or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? ☐ Yes ☐ No
4. Has the patient had a TB screening test (e.g., a tuberculosis skin test [PPD] or an interferon-release assay [IGRA]) within 6 months of initiating therapy? ☐ Yes ☐ No
5. What were the results of the TB screening test? ☐ Positive ☐ Negative
6. Does the patient have latent or active tuberculosis (TB)? ☐ Latent ☐ Active ☐ No/Neither
7. If the patient has latent or active tuberculosis, has treatment been initiated or completed?
   ☐ Yes - treatment initiated ☐ Yes - treatment completed ☐ No

8. Is this request for continuation of therapy? ☐ Yes ☐ No If No, skip to diagnosis section.

9. For continuation of therapy requests, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug? ☐ Yes ☐ No

10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ☐ Yes ☐ No

DIAGNOSIS SECTION ***Please only complete sections below that are relevant to the patient's diagnosis.***

Section A: Rheumatoid Arthritis

11. The patient has diagnosis of rheumatoid arthritis and the treatment is prescribed by or in consultation with a rheumatologist. ☐ Yes ☐ No

12. Has the patient previously received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:_____

* Please note, the preferred drug in this class is Cimzia, followed by Simponi, followed by Humira. Please consider prescribing 1 of these drugs before Enbrel if clinically appropriate. If Enbrel is preferred over these drugs, please provide additional clinical reasoning documentation here:_____

13. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate 25mg PO weekly* ? ☐ Yes ☐ No If the methotrexate dose is unable to be increased to 25mg PO weekly, please indicate reason: _____

14. Has the patient experienced intolerance to methotrexate? ☐ Yes ☐ No If Yes, indicate intolerance:
_____

15. Does the patient have a contraindication to methotrexate? ☐ Yes ☐ No If Yes, indicate contraindication:
_____

Section B: Juvenile Idiopathic Arthritis (polyarticular, oligoarticular, systemic)

16. Has the patient previously received a biologic indicated for moderately to severely active articular juvenile idiopathic arthritis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:_____

* Please note, the preferred drug in this class is Humira. Please consider prescribing this drug before Enbrel if clinically appropriate. If Enbrel is preferred, please provide additional clinical reasoning documentation here:
_____

17. Has the patient had an inadequate response to methotrexate or another non-biologic DMARD administered at an adequate dose and duration? ☐ Yes ☐ No

18. Does the patient have any of the following risk factors: a) positive rheumatoid factor or anti-CCP, b) pre-existing joint damage, c) high disease activity or high risk for disabling joint disease? ☐ Yes ☐ No

Section C: Ankylosing Spondylitis, or Peripheral/Axial Spondyloarthritis (Seronegative Spondyloarthropathy)

19. The patient is diagnosed ankylosing spondylitis or peripheral/axial spondyloarthritis, and the treatment is prescribed by or in consultation with a rheumatologist. ☐ Yes ☐ No

20. Has the patient previously received a biologic indicated for active ankylosing spondylitis? ☐ Yes ☐ No
If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
_____

* Please note, the preferred drug in this class is Cimzia, followed by Simponi, followed by Humira. Please consider prescribing 1 of these drugs before Enbrel if clinically appropriate. If Enbrel is preferred over these agents, please provide additional clinical reasoning documentation here: _____

21. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ☐ Yes ☐ No

Section D: Psoriasis

22. The patient is diagnosed with psoriasis and treatment is prescribed by or in consultation with a dermatologist or rheumatologist ☐ Yes ☐ No

23. Has the patient previously received Otezla or any other biologic medication indicated for the treatment of moderate to severe plaque psoriasis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable: _____

* Please note, the preferred drug in this class is Humira. Please consider prescribing this drug before Enbrel if clinically appropriately. If Enbrel is preferred, please provide additional clinical reasoning documentation here:
_____

24. Has the patient had an inadequate response to 1 or more of the following topical therapies?
    - ☐ Corticosteroids (e.g., betamethasone, clobetasol, desonide) (4-week trial)
    - ☐ Vitamin D analogs (e.g., calcitriol, calcipotriene)
    - ☐ Tazarotene
    - ☐ Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
    - ☐ Anthralin
    - ☐ Coal tar

25. Has the patient had an inadequate response to a minimum 3 month trial of methotrexate at a minimum dose of 15mg po weekly within the last 6 months? ☐ Yes ☐ No

26. Does the patient have a contraindication or intolerance to methotrexate? ☐ Yes ☐ No If Yes, indicate contraindication/intolerance and no further questions._____

27. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected)? ☐ Yes ☐ No

Section E: Psoriatic Arthritis

28. The patient is diagnosed with psoriatic arthritis and treatment is prescribed by or in consultation with a rheumatologist ☐ Yes ☐ No

29. Has the patient previously received a biologic medication, apremilast (Otezla), or targeted synthetic DMARD (e.g., Xeljanz) indicated for the treatment of psoriatic arthritis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

* Please note, the preferred drug in this class is Cimzia, followed by Simponi, followed by Humira. Please consider prescribing 1 of these drugs before Enbrel if clinically appropriately. If Enbrel is preferred over these agents, please provide additional clinical reasoning documentation here:_____

30. Has the patient experienced an inadequate response after at least 3 months of treatment with 1 or more of the following medications at the maximally tolerated dose?
    - ☐ Methotrexate – minimum dose 15mg po weekly
    - ☐ Sulfasalazine – minimum dose 2g po weekly
    - ☐ Cyclosporine
    - ☐ Leflunomide

☐ Apremilast (Otezla)

31. Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No
If yes, please document medications and respective contraindications/intolerances:
_____

Section F: Hidradenitis Suppurativa

32. Has the patient previously received a biologic medication indicated for the treatment of moderate to severe hidradenitis suppurativa? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable: _____

* Please note, the preferred drug in this class is Humira. Please consider prescribing this drug before Enbrel if clinically appropriately. If Enbrel is preferred, please provide additional clinical reasoning documentation here:
_____

33. Has the patient experienced an inadequate response after at least 3 months of treatment with oral antibiotics? ☐ Yes ☐ No

34. Has the patient experienced an intolerable adverse effect to oral antibiotics? ☐ Yes ☐ No

35. Does the patient have a contraindication to oral antibiotics? ☐ Yes ☐ No

Section G: Behcet's Disease

36. Has the patient received Otezla or a biologic indicated for the treatment of Behcet's disease? ☐ Yes ☐ No
If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
_____

* Please note, the preferred drug in this class is Humira. Please consider prescribing this drug before Enbrel if clinically appropriately. If Enbrel is preferred, please provide additional clinical reasoning documentation here:
_____

37. Has the patient had an inadequate response to at least one nonbiologic medication for Behcet's disease (apremilast, colchicine, systemic corticosteroids, azathioprine)? ☐ Yes ☐ No

Section H: Pyoderma Gangrenosum

38. Has the patient received a biologic indicated for the treatment of pyoderma gangrenosum? ☐ Yes ☐ No
If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
_____

* Please note, the preferred drug in this class is Humira. Please consider prescribing this drug before Enbrel if clinically appropriately. If Enbrel is preferred, please provide additional clinical reasoning documentation here:
_____

39. Has the patient experienced an inadequate response to systemic corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ☐ Yes ☐ No

40. Has the patient experienced an intolerance to systemic corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ☐ Yes ☐ No

41. Does the patient have a contraindication to systemic corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ☐ Yes ☐ No

Section I: Graft vs. Host Disease (acute or chronic)

42. Has the patient experienced an inadequate response to topical or systemic corticosteroids or immunosuppressive therapy (e.g., cyclosporine or mycophenolate mofetil)? ☐ Yes ☐ No

43. Has the patient experienced an intolerance to topical or systemic corticosteroids or immunosuppressive therapy (e.g., cyclosporine or mycophenolate mofetil)? ☐ Yes ☐ No

44. Does the patient have a contraindication to topical or systemic corticosteroids or immunosuppressive therapy (e.g., cyclosporine or mycophenolate mofetil)? ☐ Yes ☐ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Sendero Health Plans.	
Prescriber or Authorized Signature	DATE