aetna®

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:
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 #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	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 ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Enbrel: ☐ 25mg or ☐ 50mg **Frequency:** _____ **Start date:** ____/____/____

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 etanercept (Enbrel) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., Cosentyx, Humira, Remicade, etc)?

☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the date and results of the TB test: Date: ____/____/____ Results: ☐ 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 etanercept (Enbrel)

Ankylosing spondylitis

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

☐ Yes ☐ No Has the patient had an inadequate response to two or more non-steroidal anti-inflammatory drugs (NSAIDs)?
→ Please provide the names and date ranges: NSAID #1: _____ Date range: ____/____/____ to ____/____/____
NSAID #2: _____ Date range: ____/____/____ to ____/____/____

Behcet's Disease

☐ Yes ☐ No Has the disease been refractory to glucocorticoids and azathioprine?
→ Please provide the date range of the glucocorticoid use: ____/____/____ to ____/____/____
Please provide the date range of azathioprine use: ____/____/____ to ____/____/____

Continued on next page

aetna®

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:
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

Juvenile idiopathic arthritis (juvenile rheumatoid arthritis)

What is the severity of the patient's disease? ☐ Mild ☐ Moderate ☐ Severe

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

Plaque Psoriasis (adult)

What is the severity of the patient's disease? ☐ Mild ☐ Moderate ☐ Severe

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

☐ Yes ☐ No Is there clinical documentation of chronic disease?

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 involve sensitive areas? ***If yes***, please select: ☐ hands ☐ feet ☐ face ☐ genitals

☐ Yes ☐ No Is the patient a candidate for systemic treatment with conventional DMARD(s)?

→ ☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?

Provide the name and date range: Name: _____ Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) not tolerated?

☐ Yes ☐ No Are systemic conventional DMARDs contraindicated?

☐ Yes ☐ No Is the patient a candidate for phototherapy?

→ ☐ Yes ☐ No Was the trial with phototherapy ineffective?

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

Date range of phototherapy use: ____/____/____ to ____/____/____

☐ Yes ☐ No Was the trial with phototherapy not tolerated?

☐ Yes ☐ No Is phototherapy contraindicated?

Plaque Psoriasis (pediatric)

What is the severity of the patient's disease? ☐ Mild ☐ Moderate ☐ Severe

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

☐ Yes ☐ No Is there clinical documentation of chronic disease?

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 involve sensitive areas? ***If yes***, please select: ☐ hands ☐ feet ☐ face ☐ genitals

☐ Yes ☐ No Is the patient a candidate for phototherapy?

☐ Yes ☐ No Has the patient failed to adequately respond to or was the patient intolerant to a trial of phototherapy?

→ *Check ALL that apply:* ☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
☐ UVB with coal tar or dithranol
☐ UVB (standard or narrow-band)
☐ Home UVB

Date range of phototherapy use: ____/____/____ to ____/____/____

Psoriatic Arthritis

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

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?

→ ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate?

If yes, date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Does the patient have an intolerance or contraindication to methotrexate?

☐ Yes ☐ No Has the patient had an inadequate response to at least 1 (other than methotrexate) non-biologic disease-modifying anti-rheumatic drug (DMARD)? If yes, provide the name and date range used:

Name: _____ Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?

→ ☐ Yes ☐ No Has the patient had an inadequate response to at least 2 non-steroidal anti-inflammatory drugs (NSAIDs)?

If yes, provide the names and date ranges: NSAID #1: _____ Date range: ____/____/____ to ____/____/____

NSAID #2: _____ Date range: ____/____/____ to ____/____/____

Reactive Arthritis (Reiter's syndrome)

☐ Yes ☐ No Does the patient have reactive arthritis?

☐ Yes ☐ No Was treatment with methotrexate ineffective? ***If yes***, date range of use: ____/____/____ to ____/____/____

☐ Yes ☐ No Was treatment with sulfasalazine ineffective? ***If yes***, date range of use: ____/____/____ to ____/____/____

☐ Yes ☐ No Was treatment with steroids ineffective? ***If yes***, date range of use: ____/____/____ to ____/____/____

☐ Yes ☐ No Was treatment with non-steroidal anti-inflammatory drugs (NSAIDS) ineffective?

→ Provide the name and date range: NSAID: _____ Date range: ____/____/____ to ____/____/____

Continued on next page

aetna®

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:
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

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?

For continuation of therapy:

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

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

☐ 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 date and results of the TB test: Date: ____/____/____

Results: ☐ Positive ☐ Negative ☐ Unknown

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.