

Prescriber Criteria Form
 Etanercept 2025 PA Fax 6570-A v1 010125.docx
 Enbrel (etanercept)
 Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
 Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Enbrel (etanercept).

Drug Name:
 Enbrel (etanercept)

Patient Name:		
Patient ID:		
Patient DOB:	Patient Phone:	
Prescriber Name:		
Prescriber Address:		
City:	State:	Zip:
Prescriber Phone:	Prescriber Fax:	
Diagnosis:	ICD Code(s):	

Please circle the appropriate answer for each question.

		Yes	No
1	Has the patient previously received the requested drug for one of the following conditions: A) rheumatoid arthritis, B) polyarticular juvenile idiopathic arthritis, C) ankylosing spondylitis, D) psoriatic arthritis, E) plaque psoriasis, F) hidradenitis suppurativa, G) non-radiographic axial spondyloarthritis? [If yes, then no further questions.]		
2	Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis (RA)? [If no, then skip to question 4.]		
3	Does the patient meet either of the following criteria: A) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX), B) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD? [No further questions.]		
4	Does the patient have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis? [If yes, then no further questions.]		

5	Does the patient have a diagnosis of active psoriatic arthritis? [If yes, then no further questions.]	Yes	No
6	Does the patient have a diagnosis of active ankylosing spondylitis or non-radiographic axial spondyloarthritis? [If no, then skip to question 8.]	Yes	No
7	Does the patient meet either of the following: A) patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID), B) patient has a contraindication that would prohibit a trial of NSAIDs? [No further questions.]	Yes	No
8	Does the patient have a diagnosis of moderate to severe plaque psoriasis? [If no, then skip to question 11.]	Yes	No
9	Does the patient meet one of the following criteria: A) at least 3 percent of body surface area (BSA) is affected by plaque psoriasis at the time of diagnosis, B) crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected by plaque psoriasis at the time of diagnosis? [If no, then no further questions.]	Yes	No
10	Does the patient meet any of the following criteria: A) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., ultraviolet B [UVB], psoralen plus ultraviolet A [PUVA]) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, B) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, C) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10 percent of the body surface area [BSA] or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals, groin, intertriginous areas] are affected)? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of severe, refractory hidradenitis suppurativa? [If yes, then no further questions.]	Yes	No
12	Does the patient have a diagnosis of active juvenile psoriatic arthritis (JPsA)?	Yes	No

Comments:	
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By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____	Date: _____
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