AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Enbrel® (etanercept)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

NOTE: AvMed considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ **Diagnosis: Rheumatoid Arthritis**
  Dosing: SubQ: 50 mg once weekly

  - ❑ Member has a diagnosis of moderate-to-severe active **rheumatoid arthritis**
  - ❑ Prescribed by or in consultation with a **Rheumatologist**

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- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine

❑ **Diagnosis: Polyarticular Juvenile Idiopathic Arthritis**
Dosing:
- Weight < 63 kg: SubQ: 0.8 mg/kg/dose once weekly; maximum dose: 50 mg/dose
- Weight ≥ 63 kg: SubQ: 50 mg once weekly

- ❑ Member has a diagnosis of moderate-to-severe active polyarticular **juvenile idiopathic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member is ≥ 2 years of age
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ non-steroidal anti-inflammatory drugs (NSAIDs)
  - ❑ oral corticosteroids
  - ❑ sulfasalazine
  - ❑ tacrolimus

❑ **Diagnosis: Psoriatic Arthritis**
Dosing: SubQ: 50 mg once weekly

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member is ≥ 2 years of age
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine

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❑ **Diagnosis: Ankylosing Spondylitis**
Dosing: SubQ: 50 mg once weekly

- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs

❑ **Diagnosis: Plaque Psoriasis**
Dosing: SubQ: Initial: 50 mg twice weekly for 3 months. **Maintenance:** 50 mg once weekly

- ❑ Member has a diagnosis of moderate-to-severe chronic **plaque psoriasis**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member is ≥ 4 years of age
- ❑ Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months** (check each tried below):

❑ **Phototherapy:**	❑ **Alternative Systemic Therapy:**
❑ **UV Light Therapy**	❑ **Oral Medications**
❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy & Therapeutics Committee:** ~~9/17/2009;~~ **11/16/2023**
REVISED/UPDATED: ~~6/3/2011; 8/12/2011; 1/16/2014; 2/5/2014; 2/25/2014; 4/3/2014; 4/28/2014; 5/2/2014; 8/8/2014; 10/30/2014; 5/21/2015; 12/27/2015; 8/12/2016; 9/22/2016; 12/11/2016; 8/3/2017; 12/11/2017; 1/2/2018; 1/11/2018; 11/24/2018; 9/28/2019; 11/26/2019; 2/4/2022; 12/20/2022;~~ **12/11/2023**