Physician's Prior Authorization Questionnaire
Enbrel® (*for Plaque Psoriasis*)

Patient: **ID#:** **DOB:**

Patient Address:

Enbrel® is covered only for certain conditions. Please complete the questions below to assist us in making a determination of this patient's eligibility for coverage for this therapy.

1. What is this patient's diagnosis? (*Please do not use codes.*) ____________________
2. Please detail the clinical course and current state of disease progression. ____________________
3. What is the patient's age? __________
4. What previous medications have been prescribed and the duration of therapy? ____________________
5. What percent of body surface area is involved? __________
6. Is the patient currently receiving immunosuppressant or photo therapy? ☐ Yes ☐ No
7. What is the Physician's specialty? ____________________

Enbrel® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature	Date	
Please **Print** Physician's Name & Specialty	Phone Number	Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx

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