

**Physician's Prior Authorization Questionnaire
Enbrel®**

(for Rheumatoid Arthritis, Juvenile RA, Psoriatic Arthritis, or Ankylosing Spondylitis)

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. Is the treatment for a patient with psoriatic arthritis with psoriasis who had an inadequate response to non-steroidal anti-inflammatory drugs? Yes No
4. What is the patient's current Rx therapy? _____
5. What is the duration of present Rx therapy? _____
6. Please list the medications that have been tried, the duration and a brief description of the type of failure:

7. Is the patient currently experiencing a failed therapy? Yes No
If Yes, please list details: _____

8. Has Methotrexate been attempted? Yes No
If Yes, how long has the patient been on Methotrexate? _____
9. Has Arava® been tried? Yes No
If Yes, has the patient experienced failure and if so, how? _____

If No, is Arava® contraindicated for this patient and if so, why? _____

10. Please clarify current therapy failures on slow-acting agents with explanation as to why this patient requires Enbrel®: _____

11. How long do you anticipate this treatment to last? _____

12. 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