US Family Health Plan
Prior Authorization Request Form for
etanercept (**Enbrel**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD. Humira is the Department of Defense's preferred targeted biologic agent for FDA approved indications.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **3**	☐ No proceed to question **2**
2. Is the patient between the ages of 4 and 17 years old AND has a diagnosis of plaque psoriasis?	☐ Yes proceed to question **6**	☐ No proceed to question **5**
3. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **6**	☐ No proceed to question **4**
4. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers, including ENBREL. Is the prescriber aware of this?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient 18 years of age or older?	☐ Yes proceed to question **9**	☐ No proceed to question **8**

8. Is the patient 2 to 17 years of age? (that is, age 2 through 17 years)	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
9. What is the indication or diagnosis in this adult patient?	☐ Moderate to severe active **rheumatoid arthritis** – Proceed to question **11** ☐ Active **psoriatic arthritis** – Proceed to question **11** ☐ active **ankylosing spondylitis** – Proceed to question **12** ☐ Moderate to severe chronic **plaque psoriasis** in a patient who may benefit from taking injection or pills (systemic therapy) or phototherapy – Proceed to question **11** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
10. What is the indication or diagnosis in this pediatric patient?	☐ Moderate to severe active polyarticular **Juvenile Idiopathic Arthritis** – Proceed to question **15** ☐ **Plaque psoriasis** – Proceed to question **13** ☐ Other indication, age or diagnosis – **STOP: Coverage not approved.**	
11. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
12. Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
13. What is the age of the patient?	☐ LESS than 4 years of age - **STOP Coverage not approved** ☐ 4 years of age to LESS than 6 years of age - proceed to question **15** ☐ 6 years of age and OLDER - proceed to question **14**	
14. Has the patient had a trial of Stelara?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Will the patient be receiving other targeted immunomodulatory biologics with Enbrel, including but not limited to the following: Actemra, Cimzia, Cosentyx, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rinvoq, Rituxan, Siliq, Simponi, Skyrizi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____