

# Enbrel

## Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.**

**1. Patient information**

**2. Physician information**

Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

**3. Medication**

**4. Strength**

**5. Directions**

**6. Quantity per 30 days**

Enbrel			Specify:
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**7. Diagnosis:**

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**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	The requested medication is being provided and billed at the physician’s office?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the member have a diagnosis of rheumatoid arthritis, ankylosing spondylitis and/or psoriatic arthritis in the last 730 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the member have a diagnosis of plaque psoriasis in the last 730 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the member have a diagnosis of polyarticular juvenile idiopathic arthritis in the last 730 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the member have a history of heart failure in the last 365 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the member have a history of demyelinating disease (multiple sclerosis, optic neuritis and/or Guillain-Barre syndrome) in the last 365 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the member have a history of hematologic abnormalities in the last 180 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the member have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the

[provider.wellpoint.com/tx/](http://provider.wellpoint.com/tx/)

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

last 180 days?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <http://www.txvendordrug.com/formulary/formulary-search.asp>.

**9. Physician signature**

\_\_\_\_\_  
Prescriber or authorized signature

\_\_\_\_\_  
Date

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.*

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