CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Enbrel® (etanercept)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐696.1 Psoriasis ☐696.0 Psoriatic Arthritis ☐714.0 Rheumatoid Arthritis ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY TO THE DIAGNOSIS.

NOTE: Areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

REQUIRED FOR ALL (none of the following can be present):

- Patient has a latex allergy ☐ Yes ☐ No
- Patient has tuberculosis or a history of recurrent, chronic current, or clinically important infection ☐ Yes ☐ No
- Patient had a tuberculin skin test to rule out latent tuberculosis ☐ Yes ☐ No
- Patient has a history of systemic malignancy within the last 5 years ☐ Yes ☐ No
- Patient has moderate to severe (NYHA Class III/IV) Congestive Heart Failure (CHF) ☐ Yes ☐ No
- Patient has Multiple Sclerosis or any other demyelinating disease ☐ Yes ☐ No
- Will the patient receive live vaccines while receiving Enbrel? ☐ Yes ☐ No
- Patient will use Enbrel in combination with other TNF agents or Kineret ☐ Yes ☐ No
- Patient is currently receiving systemic psoriasis therapy (except for methotrexate, glucocorticoids, salicylates, non-steroidal anti-inflammatory drugs, or analgesics), Immunosuppressive therapy, or Anakinra ☐ Yes ☐ No
  - Comments: _____

Ankylosing Spondylitis:

- Patient is 18 years of age or older ☐ Yes ☐ No
- Patient has diagnosis of Ankylosing Spondylitis ☐ Yes ☐ No
- Patient has failed, had inadequate response to, or is contraindicated for treatment with sulfasalazine, methotrexate, or non-steroidal anti-inflammatory drugs ☐ Yes ☐ No

Chronic Plaque Psoriasis:

- Patient is 18 years of age or older ☐ Yes ☐ No
- Patient has a diagnosis of moderate to severe plaque psoriasis with either of the following: ☐ Yes ☐ No
  - ☐ Patient has greater than 10% of body surface area with plaque psoriasis
  - ☐ Less than or equal to 10% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of Feet, head/neck, or genitailia)
  - ☐ Other: _____
- Is the psoriasis controlled with topical therapy? ☐ Yes ☐ No
- Patient has failed, has a contraindication, or is intolerant to, but is otherwise a candidate for other systemic therapies (e.g., methotrexate, acitretin, or cyclosporine) or phototherapy ☐ Yes ☐ No

Moderate to severely active Juvenile Rheumatoid Arthritis (under 18 years of age):

- Has the patient failed or had an inadequate response to 1 or more DMARDs? ☐ Yes ☐ No

If Yes, what DMARD has the patient tried?

☐ Azulfidine (sulfasalazine)	☐ Methotrexate	☐ Cytoxan
☐ Cuprimine/Depen (penicillamine)	☐ Plaquenil (hydroxychloroquine)	☐ Cyclosporine (Neoral or Sandimmune)
☐ Imuran (azothioprine)	☐ Ridaura (auranofin)	☐ Minocycline (Minocin or Dynacin)
☐ Lefkybinude (Arava)	☐ Gold Sodium Thiomalate (Myochrysine)	☐ Other: _____

CONTINUED ON PAGE 2 – PAGE 1 OF 2

Active Psoriatic Arthritis:

- Patient is 18 years of age or older ☐ Yes ☐ No
- Patient has active arthritis with at least 3 swollen and 3 tender joints ☐ Yes ☐ No
- Patient has arthritis in **any** of the following distributions: ☐ Yes ☐ No

☐ Ankylosing Spondylitis-like Arthritis ☐ Asymmetric Arthritis
☐ Arthritis Mutilans ☐ Distal Interphalangeal Joint Involvement
☐ Polyarticular Arthritis, without Rheumatoid Nodules

- Patient has failure or contraindicated for disease-modifying antirheumatic drugs (DMARD) therapy, specifically methotrexate or sulfasalazine ☐ Yes ☐ No

Moderate to severely active Rheumatoid Arthritis:

- Patient has failed or had an inadequate response to 1 or more DMARDs? ☐ Yes ☐ No

If Yes, what DMARD has the patient tried?

☐ Azulfidine (sulfasalazine) ☐ Methotrexate ☐ Cytoxan
☐ Cuprimine/Depen (penicillamine) ☐ Plaquenil (hydroxychloroquine) ☐ Cyclosporine (Neoral or Sandimmune)
☐ Imuran (azothioprine) ☐ Ridaura (auranofin) ☐ Minocycline (Minocin or Dynacin)
☐ Lefkybinude (Arava) ☐ Gold Sodium Thiomalate (Myochrysine) ☐ Other: _____

Note: Enbrel (etanercept) may be administered with methotrexate if patient is not responding adequately to methotrexate alone.

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Enbrel® (etanercept)	☐ 50mg/ml Sureclick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg Vial	☐ Inject 50mg SC TWICE a week (72-96 hours apart) ☐ Inject 50mg SC ONCE a week ☐ Inject 25mg SC TWICE a week (72-96 hours apart) ☐ Other: _____		

PRODUCT SUBSTITUTION PERMITTED (Date)

DISPENSE AS WRITTEN (Date)