Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Enbrel

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this an initial request or re-authorization request?

☐ Initial request ☐ Re-authorization request

Q2. What is the diagnosis?

☐ Rheumatoid Arthritis (RA)
☐ Polyarticular Juvenile Idiopathic Arthritis (pJIA)
☐ Juvenile Psoriatic Arthritis (jPsA)
☐ Ankylosing Spondylitis (AS)
☐ Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
☐ Moderate to Severe Plaque Psoriasis (PsO)
☐ Psoriatic Arthritis (PsA)
☐ Other

Q3. If other, please specify:

Q4. Is there documentation of diagnosis with chart notes attached?

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Enbrel

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q5. Is the patient within the age group listed in the FDA labeling for the indication?

☐ Yes ☐ No

Q6. For the diagnosis Rheumatoid Arthritis (RA), is there documentation of inadequate response, intolerance, or contraindication to at least one conventional DMARD (e.g., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) OR has the member had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q7. For the diagnosis Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (pJIA), Juvenile Psoriatic Arthritis (jPsA), is there documentation of inadequate response, intolerance, or contraindication to at least one conventional DMARD (e.g., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) OR has the member had a 3-month trial of a bDMARD or tsDMARD for the requested indication?
Yes

☐ Yes ☐ No

Q8. For the diagnosis Ankylosing Spondylitis (AS) and, Non-Radiographic Axial Spondyloarthritis (nr-axSpA), is there documentation of inadequate response, intolerance, or contraindication to at least two non-steroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes ☐ No

Q9. For the diagnosis moderate to severe plaque psoriasis (PsO): Is there documentation that the member is a candidate for systemic therapy or phototherapy?

☐ Yes ☐ No

Q10. Is there documentation of inadequate response, intolerance, or contraindication to one of the following: methotrexate, UVB therapy, or acitretin OR has the member had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Enbrel

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q11. For the diagnosis psoriatic arthritis (PsA), Ddoes the member have one of the following?

☐ Documentation of inadequate response, intolerance, or contraindication to a cDMARD (e.g., methotrexate, leflunomide, or sulfasalazine) OR has the member had a 3-month trial of a bDMARD or tsDMARD for the requested indication
☐ Has axial disease, dactylitis, and/or enthesitis
☐ Has severe disease as determined by prescriber
☐ Has concomitant moderate to severe nail disease
☐ Has concomitant active inflammatory bowel disease
☐ None of the above

Q12. Is there confirmation of positive clinical response?

☐ Yes ☐ No

Q13. A coverage consideration cannot be considered without the submission of medical chart documentation supporting your responses. Have you attached all required documentation?

☐ Yes ☐ No

Q14. Has the provider attached all necessary medical chart documentation?

☐ Yes ☐ No

Q15. Additional Information:

_____ _____

Prescriber Signature Date

v2026

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document