



**ETANERCEPT (ENBREL®)  
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING  
ALL NC PROVIDERS MUST PROVIDE THEIR 5 DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**                      **Dx Code:** \_\_\_\_\_

- A. Will the patient be receiving treatment with more than one biologic agent at the same time?  
(e.g., Humira, Kineret, Cimzia, Simponi, Remicade, Orencia or Rituxan) .....  Yes  No
- B. Has the patient been screened for the presence of latent TB? .....  Yes  No

**C. Please check the appropriate diagnosis and answer the related questions:**

**Rheumatoid Arthritis or Psoriatic Arthritis**

1. Has the patient experienced a therapeutic failure/inadequate response with Methotrexate (MTX) or has a contraindication? .....  Yes  No
- OR**
2. Is the patient being treated for rapidly progressive and advancing disease? .....  Yes  No

**Ankylosing Spondylitis**

**Plaque Psoriasis**

1. Is the patient being managed by a dermatologist? .....  Yes  No
2. Does the patient have Body Surface Area (BSA) involvement of at least 5% or involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities or employment? .....  Yes  No
3. Has the patient tried and failed systemic therapy (e.g., Methotrexate, Cyclosporine, Acitretin [Soriatane®]) or has a contraindication to these therapies? .....  Yes  No

If yes, list agents and/or contraindications: \_\_\_\_\_

**\*\*\*PLEASE NOTE: If you are prescribing greater than 200 mg of Enbrel per month please complete and sign page 2.**

**Please certify the following by signing and dating below:**

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): \_\_\_\_\_ Date: \_\_\_\_\_

**Fax completed form to BCBSNC at 1-800-795-9403**

**COMPLETE PAGE 2 ONLY IF REQUESTING A QUANTITY LIMIT  
EXCEPTION FOR ENBREL**

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PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

**If you are requesting a quantity above the amount listed, check the appropriate box and provide the medical necessity of the increased dosage requested.**

***Please note:** This medication requires a **prior authorization** before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (page 1). Otherwise, this request will deny.*

**Dx Code:** \_\_\_\_\_

Requested drug dose:

greater than 200 mg of Enbrel every 28 days

Provide dosage requested and a description of medical necessity / rationale for this request:

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Prescriber's Signature (Required): \_\_\_\_\_ Date: \_\_\_\_\_

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