

# ENBREL® PRIOR REVIEW FAXBACK FORM

PROVIDER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID	PATIENT NAME
CONTACT PERSON		PATIENT'S BCBSNC ID
PHONE	FAX	PATIENT'S DATE OF BIRTH

**Please check the appropriate diagnosis and answer the corresponding questions:**

- Rheumatoid Arthritis or Psoriatic Arthritis**
- Has the patient experienced a therapeutic failure/inadequate response with Methotrexate (MTX) or has a contraindication?.....  Yes  No
- OR**
- Is the patient being treated for rapidly progressive and advancing disease?.....  Yes  No
  - Has the patient been screened for the presence of latent TB?.....  Yes  No
- Plaque Psoriasis**
- Is the patient being managed by a dermatologist?.....  Yes  No
  - 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
  - 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: \_\_\_\_\_
- Has the patient been screened for the presence of latent TB?.....  Yes  No

**Note:** The Enbrel® manufacturer's suggested dosing for Plaque Psoriasis is 50mg twice weekly for 3 months, followed by a reduction to maintenance dose of 50mg per week.

- Ankylosing Spondylitis**
- Other Pertinent Information:** \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

I certify that, to the best of my knowledge, the information above is accurate.

Prescriber's Signature Required: \_\_\_\_\_

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