



ENBREL® (etanercept) - Prior Authorization/Prescription/Patient Enrollment Form

Complete form in its entirety and fax to number listed below

PATIENT INFORMATION

Last Name		First Name		Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #		
Allergies: <input type="checkbox"/> NKA or _____				
Street Address		City		Zip Code
State	County	Cell Phone	Day Telephone	
Home Phone	Parent/Guardian	Relationship	Night Telephone	
Emergency Contact	Telephone			

PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name
Street Address	City	
State	County	Zip Code
Contact Person at Office	Prescriber Specialty	



Fax Completed Form to:
Fax Number: 800-218-3221
Phone Number: 866-843-3604

Department of Vermont Health Access
ENBREL® (etanercept)
PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

- Rheumatoid Arthritis
- Psoriatic Arthritis
- Juvenile Idiopathic Arthritis
- Ankylosing Spondylitis
- Plaque Psoriasis

If requesting prescriber is not a Rheumatologist or Dermatologist, has one of these specialties been consulted on this case? Yes No

Specialist name: _____ Specialist Type: _____

List previous medications/therapies tried and failed for this condition: (include oral, injectable, topical, phototherapy etc.)

Therapy (and dates) _____ Reason for discontinuation _____

Prescriber Additional Comments:

PRESCRIPTION

Dosage Form and Quantity:

- Enbrel 25 mg prefilled syringe _____ Dispense Quantity: _____
- Enbrel 25 mg multi-use vial _____ Dispense Quantity: _____
- Enbrel 50mg prefilled syringe _____ Dispense Quantity: _____
- Enbrel 50mg SureClick autoinjector _____ Dispense Quantity: _____

Sig: Dose/Route/Frequency: _____

Refill X: _____

Deliver product to: Patient's home MD office Clinic
 Prescriber's Signature: _____ Date: _____