



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

Complete form in its entirety and fax to number listed below

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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	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

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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

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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:

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PRESCRIPTION

Dosage Form and Quantity:

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