

Drug Coverage Review Request

Enbrel[®]



SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

PRESCRIBER

MD First Name _____
MD Last Name _____
Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____
DEA number (optional) _____

PATIENT

Cardholder ID # _____
Patient Last Name _____
Patient First Name _____
Date of Birth _____
Address _____
City _____
State _____
Zip Code _____
Phone _____

Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

SECTION A

Please answer the following questions

- Yes No Will the patient be receiving MORE THAN ONE biologic rheumatoid arthritis agent (*Enbrel, Kineret, Humira, Remicade, Orencia or Rituxan*) AT THE SAME TIME?
- Where warranted, will the patient be evaluated and screened for the presence of latent TB infection prior to initiation of therapy with this drug?
 Not Warranted
- For which indication is this drug being prescribed? (**please choose one primary indication below**)
 - Moderate to severe rheumatoid arthritis (RA) or psoriatic arthritis (PsA) (**please answer questions 4-8**)
 - Rapidly advancing, progressive rheumatoid arthritis
 - Moderate to severe juvenile idiopathic arthritis (JIA)/juvenile rheumatoid arthritis (JRA)
 - Ankylosing spondylitis (**please answer questions 9-11**)
 - Moderate to severe plaque psoriasis
 - Other

Questions 4-8 apply only if diagnosis is **moderate to severe rheumatoid arthritis or psoriatic arthritis**

- Yes No Is the patient CURRENTLY RECEIVING this drug?
- Yes No **IF YES TO PREVIOUS QUESTION**, has drug therapy provided SIGNIFICANT IMPROVEMENT in the patient's condition?
 Not Applicable
- Yes No Will the patient be receiving THIS DRUG AND METHOTREXATE at the same time?
- Yes No If the patient is not currently receiving methotrexate, has therapy with methotrexate FAILED TO TREAT the patient's condition?
- Yes No Is the patient a CANDIDATE FOR RECEIVING methotrexate?

Please continue on Page 2



Confidentiality Notice: This communication and any attachments are intended solely for the use of the addressee named above and contain confidential and legally privileged information. If you are not the intended recipient, any dissemination, distribution or copying is strictly prohibited. If you receive this communication in error, please notify Medco by fax or phone immediately. Medco facsimile machines are secure and in compliance with HIPAA privacy standards. **THE PROVISION OF THE INFORMATION REQUESTED IN THIS FORM IS FOR YOUR PATIENT'S BENEFIT. MEDCO DOES NOT COMPENSATE FOR COMPLETING THIS FORM.**

Continued from page 1

Questions 9-11 apply only if diagnosis is **ankylosing spondylitis**

9. Yes No Has the patient received AT LEAST TWO OF THE FOLLOWING drugs: NSAIDS OR A COX-2 INHIBITOR?
10. Yes No **IF YES TO PREVIOUS QUESTION**, has the patient EXPERIENCED INADEQUATE SYMPTOM RELIEF from AT LEAST TWO NSAIDs and/or COX-2 Inhibitors?
11. Yes No Is the patient UNABLE TO RECEIVE drug therapy with NSAIDs or a COX-2 inhibitor?

SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1 800 837-0959

PLEASE DO NOT FAX WITH A COVER SHEET

Confidentiality Notice: This communication and any attachments are intended solely for the use of the addressee named above and contain confidential and legally privileged information. If you are not the intended recipient, any dissemination, distribution or copying is strictly prohibited. If you receive this communication in error, please notify Medco by fax or phone immediately. *Medco facsimile machines are secure and in compliance with HIPAA privacy standards.* **THE PROVISION OF THE INFORMATION REQUESTED IN THIS FORM IS FOR YOUR PATIENT'S BENEFIT. MEDCO DOES NOT COMPENSATE FOR COMPLETING THIS FORM.**