

ENBREL (MEDICARE DETERMINATION)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Does the medication meet the Medicare definition of a drug or biological (e.g., the drug appears in the latest edition of the USP-NF or American Dental Association guide to dental therapeutics)? Y N
2. Is this an injectable formulation of the drug? Y N
3. Is the patient enrolled in Medicare Part B? Y N
4. Has this drug claim been submitted through Medicare Part B? Y N
5. Was the drug claim denied by Medicare Part B? Y N
6. Is the drug excluded from Medicare benefit coverage (e.g., immunizations, antigens)? Y N
7. Is the drug delivered through intravenous administration? Y N

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8. Is the drug administered through an implantable pump? Y N
9. Is the drug administered through an external pump? Y N
10. Is the drug included under a local coverage policy for the applicable Medicare DMERC? Y N
11. Is the drug generally self-injected by a patient more than 50% of the time in an outpatient setting? Y N
12. Is the physician purchasing and providing the drug "incident to" physician services? Y N
13. Does the patient have the diagnosis of moderate to severely active polyarticular (with multiple joint involvement) juvenile rheumatoid arthritis (JRA)? Y N
14. Does the patient have the diagnosis of moderate to severely active rheumatoid arthritis? Y N
15. Does the patient have or has the patient ever had a diagnosis of plaque psoriasis? Y N
16. Does the patient have the diagnosis of active psoriatic arthritis? Y N
17. Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis? Y N
18. Is the patient \geq 18 years of age? Y N
19. Is the patient a candidate for systemic therapy or phototherapy? Y N
20. Does the patient have a diagnosis of active ankylosing spondylitis? Y N
21. Has the patient tried and failed at least one non-steroidal anti-inflammatory drug (NSAID) OR is the use of NSAIDs contraindicated [e.g., ibuprofen, diclofenac, naproxen, indomethacin, celecoxib, rofecoxib, meloxicam]? Y N
22. Has the patient tried and failed one disease-modifying anti-rheumatic drugs (DMARDs) [e.g., Methotrexate (MTX) Imuran (azathioprine), Ridaura (oral gold), Plaquenil (hydroxychloroquine), Cuprimine (D-penicillamine), Azulfidine (sulfasalazine), Arava (leflunomide)]? Y N
23. Has the patient received at least 6 months or more of Enbrel therapy through an administered benefit? Y N
24. Has the patient been evaluated for latent tuberculosis infection? Y N
25. Did the patient have a positive tuberculin test? Y N

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26. Is the patient being treated for latent tuberculosis? Y N
27. Has the patient achieved at least a 20% improvement in arthritis symptoms since the initiation of therapy? Y N
28. Has the JRA patient achieved at least a 30% improvement in arthritis symptoms since the initiation of therapy? Y N
29. Does the patient have an active infection, including chronic or localized infection? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature: 	Date:
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