

**NC Medicaid  
Pharmacy Prior Approval  
Immunomodulators: Enbrel**

**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy (in days):  up to 30 Days  60 Days  90 Days  120 Days  180 Days  365 Days   
Other \_\_\_\_\_

**Clinical Information**

**Request for Ankylosing Spondylitis**

1. Does the beneficiary have a diagnosis of Ankylosing Spondylitis?  Yes  No
2. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection?  Yes  No
4. Has the beneficiary been tested with Hep B SAG and Core Ab?  Yes  No
5. Has the beneficiary experienced inadequate symptom relief from treatment with at least two NSAIDS?  Yes  No
6. Is beneficiary unable to receive treatment with NSAIDS due to contraindications?  Yes  No
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease?  Yes  No

**Request for Polyarticular Juvenile Idiopathic Arthritis (PJIA)**

1. Does the beneficiary have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis?  Yes  No
2. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection?  Yes  No
4. Has the beneficiary been tested with Hep B SAG and Core Ab?  Yes  No
5. Has the beneficiary tried one systemic corticosteroid (e.g. prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications?  Yes  No
6. Does the beneficiary have PJIA subtype enthesitis related arthritis?  Yes  No

**Request for Plaque psoriasis (Pediatric)**

1. Does the beneficiary have a diagnosis of plaque psoriasis and is a candidate for systemic therapy or phototherapy?  Yes  No
2. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection?  Yes  No
4. Has the beneficiary been tested with Hep B SAG and Core Ab?  Yes  No

**NC Medicaid  
Pharmacy Prior Approval**

5. Has the beneficiary experienced a therapeutic failure/inadequate response with or has a contraindication or intolerance to methotrexate?  **Yes**  **No**
6. Does the beneficiary have body surface area (BSA) involvement of at least 3%?  **Yes**  **No**
7. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment?  **Yes**  **No**

**Request for Plaque psoriasis (Adult)**

1. Does the beneficiary have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis?  **Yes**  **No**
2. Is the beneficiary 18 years of age or older?  **Yes**  **No**
3. Is the beneficiary not on another injectable biologic immunomodulator?  **Yes**  **No**
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection (not required for Otezla)?  **Yes**  **No**
5. Has the beneficiary been tested with Hep B SAG and Core Ab (not required for Otezla)?  **Yes**  **No**
6. Does the beneficiary have body surface area (BSA) involvement of at least 3%?  **Yes**  **No**
7. Has the beneficiary had involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment?  **Yes**  **No**
8. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or beneficiary has contraindications to these treatments: Soriatane (acitretin), Methotrexate, or Cyclosporine?  **Yes**  **No**
9. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira?  **Yes**  **No**
10. Are beneficiaries, Providers, and Pharmacies utilizing Siliq registered appropriately in the Siliq Risk Evaluation and Mitigation Strategy Program (REMS program) ?  **Yes**  **No**

**Request for Psoriatic Arthritis**

1. Does the beneficiary have a documented definitive diagnosis of Psoriatic Arthritis?  **Yes**  **No**
2. Is the beneficiary 18 years of age or older (OR 2 years or older for Simponi Aria)?  **Yes**  **No**
3. Is the beneficiary not on another injectable biologic immunomodulator?  **Yes**  **No**
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection?  **Yes**  **No**
5. Has the beneficiary been tested with Hep B SAG and Core Ab (not required for Otezla)?  **Yes**  **No**
6. Does the beneficiary have a documented inadequate response or inability to take methotrexate  **Yes**  **No**

**Request for Rheumatoid Arthritis**

1. Does the beneficiary have a diagnosis of Rheumatoid Arthritis?  **Yes**  **No**
2. Is the beneficiary not on another injectable biologic immunomodulator?  **Yes**  **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis?  **Yes**  **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab?  **Yes**  **No**
5. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline, sulfasalazine)?  **Yes**  **No**

**NC Medicaid  
Pharmacy Prior Approval**

6. Is the beneficiary unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities?  **Yes**  **No**
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease?  **Yes**  **No**

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.