| Prescriber Criteria Form<br><br>Etanercept 2026 PA Fax 6570-A v2 010126.docx<br>Enbrel (etanercept)<br>Coverage Determination |
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| This fax machine is located in a secure location as required by HIPAA regulations.<br>Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Enbrel (etanercept). |

| Drug Name:<br>Enbrel (etanercept) |
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| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
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| 1 | Has the patient previously received the requested drug for one of the following conditions: A) rheumatoid arthritis, B) polyarticular juvenile idiopathic arthritis, C) ankylosing spondylitis, D) psoriatic arthritis, E) plaque psoriasis, F) hidradenitis suppurativa, G) non-radiographic axial spondyloarthritis?<br>[If yes, then no further questions.] | Yes | No |
| 2 | Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis (RA)?<br>[If no, then skip to question 4.] | Yes | No |
| 3 | Does the patient meet either of the following criteria: A) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX), B) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD?<br>[No further questions.] | Yes | No |
| 4 | Does the patient have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis?<br>[If yes, then no further questions.] | Yes | No |
| 5 | Does the patient have a diagnosis of active psoriatic arthritis?<br>[If yes, then no further questions.] | Yes | No |

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| 6 | Does the patient have a diagnosis of active ankylosing spondylitis or non-radiographic axial spondyloarthritis?<br>[If no, then skip to question 8.] | Yes | No |
| 7 | Does the patient meet either of the following: A) patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID), B) patient has a contraindication that would prohibit a trial of NSAIDs?<br>[No further questions.] | Yes | No |
| 8 | Does the patient have a diagnosis of moderate to severe plaque psoriasis?<br>[If no, then skip to question 12.] | Yes | No |
| 9 | Does the patient meet one of the following criteria: A) crucial body areas [e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas] are affected at the time of diagnosis, B) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10 percent of the body surface area [BSA] is affected)?<br>[If yes, then no further questions.] | Yes | No |
| 10 | Is at least 3 percent of body surface area (BSA) affected by plaque psoriasis at the time of diagnosis?<br>[If no, then no further questions.] | Yes | No |
| 11 | Does the patient meet either of the following criteria: A) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., ultraviolet B [UVB], psoralen plus ultraviolet A [PUVA]) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, B) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated?<br>[No further questions.] | Yes | No |
| 12 | Does the patient have a diagnosis of severe, refractory hidradenitis suppurativa?<br>[If yes, then no further questions.] | Yes | No |
| 13 | Does the patient have a diagnosis of active juvenile psoriatic arthritis (JPsA)? | Yes | No |

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| Comments: | _____ |

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** _____ **Date:**_____