CONTAINS CONFIDENTIAL PATIENT INFORMATION

Anthem UM Services, Inc.

# Tumor Necrosis Factor Antagonists [Enbrel® (etanercept); Humira® (adalimumab); Remicade® (infliximab)] PreDetermination of Medical Benefits

**Complete form in its entirety and fax to UM Call Center at (404) 848-2448**

| Click on grey boxes to type | Request Date: / / |
|---|---|
| ☐ Initial Authorization Request | ☐ Subsequent Request; List Prior Auth Ref #: |
| ☐ Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions fax: (800-824-2642) | |

**1. PATIENT INFORMATION**

| Patient Last Name | Patient First Name | Anthem Member ID Number | Patient DOB / / |
|---|---|---|---|
| Contact Phone Number ( ) - | Primary Diagnosis | ICD-9 Code(s) | Patient's Weight (lbs) Date: _________ |

**2. PHYSICIAN INFORMATION**

| Physician Last Name | Physician First Name | Physician DEA or NPI Number | Physician Tax ID |
|---|---|---|---|
| Address | City | State | Zip Code |
| Office Phone Number ( ) - | Office Fax Number ( ) - | Office Contact Name and ext. | Physician Specialty |

**3. MEDICATION INFORMATION – This section serves as the active prescription – signature required.**

| Drug Name | HCPCS or CPT Code(s) | Strength / Dose | |
|---|---|---|---|
| Direction for Use (SIG) | | | |
| Date patient is scheduled to be treated (need by date) / / | Service From Date / / | Service Thru Date / / | Number of Refills |

**Ship Medication to:** ☐ MD Office ☐ Patient's Home ☐ Other: (please specify)

| 4. MEDICATION | 5. DOSE | 6. FREQUENCY | 7. DURATION |
|---|---|---|---|
| ☐ **Enbrel (J1438)**<br>☐ **Humira (J0135)**<br>☐ **Remicade (J1745)** | | | |

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

NOTE: **To avoid delays**, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended. Please provide **ALL** supporting lab results, progress notes, etc.

**FOR ENBREL (ETANERCEPT) USE**

☐ Yes ☐ No Did patient have a tuberculin skin test to rule out latent tuberculosis?
Please provide test result and date: ________________________________

☐ Yes ☐ No Does the patient have any active infections?

☐ Yes ☐ No Will Enbrel be used in combination with any other TNFs or Kineret?

**(1) Adult Rheumatoid Arthritis (RA)**

☐ Yes ☐ No Patient is ≥ 18 y.o. who has moderately to severely active RA, **AND**

☐ Yes ☐ No Patient had an inadequate response to one or more DMARDs
Please list DMARDs tried and date:

**(2) Juvenile Rheumatoid Arthritis**

☐ Yes ☐ No Patient has moderately to severely active polyarticular-course juvenile RA and had an inadequate response to one or more DMARDs

Please list DMARDs tried and date: ______________________

**(3) Adult Plaque Psoriasis**

☐ Yes ☐ No Patient is ≥ 18 y.o. who has chronic moderate to severe plaque psoriasis; **AND**

☐ Yes ☐ No Treatment resistant disease covering > 10% BSA; **OR**

☐ Yes ☐ No Less than or equal to 10% BSA involving sensitive areas or areas that would significantly impact daily function (e.g. palms, soles of feet, head/neck, or genitalia).

☐ Yes ☐ No Patient is currently receiving systemic therapies, (e.g. MTX, acitretin, cyclosporine), or phototherapy

☐ Yes ☐ No Patient has a h/o of recurrent infections, current chronic infection, or positive tuberculin skin test

☐ Yes ☐ No Patient had a systemic malignancy within the last 5 years

**(4) Adult Psoriatic Arthritis**

☐ Yes ☐ No Patient is ≥ 18 y.o and has active arthritis with at least 3 swollen and 3 tender joints, **AND**

☐ Yes ☐ No There is presence of plaque psoriasis with a qualifying target lesion of at least 2 cm in diameter, **AND**

☐ Yes ☐ No Arthritis in any of the following distributions: **AND**

☐ distal interphalangeal joints ☐ arthritis multilans ☐ Other ______________________

☐ asymmetric arthritis ☐ polyarticular arthritis without rheumatoid nodule

☐ Yes ☐ No Patient has tried and failed or has a contraindication to DMARDs, specifically MTX or sulfasalazine.

Please list DMARDs tried and date: ______________________

**(5) Active Adult Ankylosing Spondylitis**

☐ Yes ☐ No Patient is ≥ 18 y.o and has active ankylosing spondylitis, **AND**

☐ Yes ☐ No Patient has tried and failed or has a contraindication to conventional therapies, e.g. NSAIDs, sulfasalazine, or MTX

Please list therapy (ies) tried and date: ______________________

**(6) Other Arthritis**

☐ Yes ☐ No Patient has reactive arthritis

☐ Yes ☐ No Patient is ≥ 18 y.o. and has arthritis associated with inflammatory bowel disease

**FOR HUMIRA (ALALIMUMAB) USE**

☐ Yes ☐ No Did the patient have a tuberculin skin test to rule out latent tuberculosis?

Please provide test result and date: ______________________

☐ Yes ☐ No Does the patient have any active infections?

☐ Yes ☐ No Will Humira be used in combination with any other TNFs or Kineret?

**(1) Rheumatoid Arthritis (RA)**

☐ Yes ☐ No Patient has moderately to severely active RA, **AND**

☐ Yes ☐ No Patient had an inadequate response to one or more DMARDs

Please list DMARDs tried and date:

**(2) Adult Psoriatic Arthritis**

☐ Yes ☐ No Patient is ≥ 18 y.o and has active arthritis with at least 3 swollen and 3 tender joints, **AND**
☐ Yes ☐ No There is presence of plaque psoriasis with a qualifying target lesion of at least 2 cm in diameter, **AND**
☐ Yes ☐ No Arthritis in any of the following distributions: **AND**

☐ distal interphalangeal joints ☐ arthritis multilans ☐ Other
☐ asymmetric arthritis ☐ polyarticular arthritis without rheumatoid nodule ________________

☐ Yes ☐ No Patient has tried and failed or has a contraindication to DMARDs, specifically MTX or sulfasalazine.
Please list DMARDs tried and date: ________________________________

**(3) Active Adult Ankylosing Spondylitis**

☐ Yes ☐ No Patient is ≥ 18 y.o and has active ankylosing spondylitis, **AND**
☐ Yes ☐ No Patient has tried and failed or has a contraindication to conventional therapies, e.g. NSAIDs, sulfasalazine, or MTX
Please list therapy (ies) tried and date: ________________________________

**(4) Crohn's Disease**

☐ Yes ☐ No Patient is ≥ 18 y.o and has moderately to severely active Crohn's disease, **AND**
☐ Yes ☐ No Patient has tried and failed conventional therapy (ies) (e.g. NSAIDs, sulfasalazine, or MTX, **AND**
Please list therapy (ies) tried and date:________________________________
☐ Yes ☐ No Patient has not been previously treated with a TNF agent, **OR**
☐ Yes ☐ No Patient has previously been treated with Remicade but has lost response to or is intolerant to Remicade

**FOR REMICADE (INFLIXIMAB) USE**

☐ Yes ☐ No Did the patient have a tuberculin skin test to rule out latent tuberculosis?
Please provide test result and date: ________________________________
☐ Yes ☐ No Does the patient have any active infections?
☐ Yes ☐ No Will Remicade be used in combination with any other TNFs or Kineret?

**(1) Rheumatoid Arthritis (RA)**

☐ Yes ☐ No Patient is ≥ 18 y.o. and has moderately to severely active RA, **AND**
☐ Yes ☐ No Patient had an inadequate response to one or more DMARDs
Please list DMARDs tried and date:

**(2) Adult Plaque Psoriasis**

☐ Yes ☐ No Patient is ≥ 18 y.o. who has chronic severe (i.e. extensive or disabling) plaque psoriasis; **AND**
☐ Yes ☐ No Treatment resistant disease covering > 10% BSA; **OR**
☐ Yes ☐ No Less than or equal to 10% BSA involving sensitive areas or areas that would significantly impact daily function (e.g. palms, soles of feet, head/neck, or genitalia).
☐ Yes ☐ No Patient is currently receiving systemic therapies, (e.g. MTX, acitretin, cyclosporine), or phototherapy
☐ Yes ☐ No Patient has a h/o of recurrent infections, current chronic infection, or positive tuberculin skin test

**(3) Adult Psoriatic Arthritis**

☐ Yes ☐ No Patient is ≥ 18 y.o and has active arthritis with at least 5 swollen and 5 tender joints, **AND**
☐ Yes ☐ No There is presence of plaque psoriasis with a qualifying target lesion of at least 2 cm in diameter, **AND**
☐ Yes ☐ No Arthritis in any of the following distributions: **AND**

☐ distal interphalangeal joints ☐ arthritis multilans ☐ Other
☐ asymmetric arthritis ☐ polyarticular arthritis without ________________

☐ Yes ☐ No Patient has tried and failed or has a contraindication to DMARDs, specifically MTX or sulfasalazine.
Please list DMARDs tried and date: ______________________________

**(4) Active Adult Ankylosing Spondylitis**

☐ Yes ☐ No Patient is ≥ 18 y.o and has active ankylosing spondylitis, **AND**

☐ Yes ☐ No Patient has tried and failed or has a contraindication to conventional therapies, e.g. NSAIDs, sulfasalazine, or MTX
Please list therapy (ies) tried and date: ______________________________

**(5) Crohn's Disease**

☐ Yes ☐ No Patient has moderately to severely active Crohn's disease with one or more of the following symptoms, **AND**

- ☐ abdominal pain
- ☐ bleeding
- ☐ diarrhea
- ☐ intestinal obstruction
- ☐ perianal disease
- ☐ weight loss
- ☐ megacolon
- ☐ extra-intestinal manifestations (arthritis, uveitis, iritis, pyoderma gangrenosum, spondylitis, erythema nodosum, or internal fistulae)

☐ Yes ☐ No Patient has tried and failed conventional therapy (ies) (e.g. oral mesalamine, oral corticosteroids, 6-mercaptopurine, or azathioprine), **OR**
Please list therapy (ies) tried and date: ______________________________

☐ Yes ☐ No Patient has fistulizing Crohn's desease, with draining enterocutaneous and rectovaginal fistulas, for at least 3 months in duration, **OR**

☐ Yes ☐ No Patient has fistulizing or moderately to severely active Crohn's disease who has responded to prior Remicade treatments

**(6) Ulcerative Colitis**

☐ Yes ☐ No Patient has moderately to severely active ulcerative colitis, **AND**

☐ Yes ☐ No Patient has tried and failed conventional therapy (ies)
Please list therapy (ies) tried and date: ______________________________

**(7) Other Arthritis**

☐ Yes ☐ No Patient has reactive arthritis

☐ Yes ☐ No Patient is ≥ 18 y.o. and has arthritis associated with inflammatory bowel disease

**(8) Other** (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

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______________________________

______________________________

**9. PHYSICIAN SIGNATURE**

| **Prescriber's or Authorized Representative's Signature:** ______________________________ | **Date:** ____/____/______ |
|---|---|

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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**Medical Policy Reference can be found at:** www.bcbsga.com

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