

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
ENBREL (entercept) for **PLAQUE PSORIASIS**

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Age requirement: 18 years old and older
- Diagnosis of moderate to severe Plaque Psoriasis
- History of incomplete response or intolerance to one appropriate systemic agent or photo therapy.
- Negative TB skin test within the previous 12 months or history of treatment for latent TB infection
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Dermatology consultation within the last 60 days.
- Enbrel may not be given with other biologic agents such as Interferon, experimental medications or combinations.

NOTES:

Available as a Non-Traditional Medicaid Benefit.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance with medication

02/15/11

<http://health.utah.gov/medicaid/pharmacy>