Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Cytokine & CAM Antagonists: etanercept (ENBREL)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:
1. Medication Requested (Name): (Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

6. Does the member have a diagnosis of ankylosing spondylitis (AS), psoriatic arthritis (PsA) and/or rheumatoid arthritis (RA) in the last 730 days?

- ◯ Yes
  (Go to #9)
- ◯ No
  (Go to #7)

7. Does the member have a diagnosis of plaque psoriasis (PS) in the last 730 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

8. Does the member have a diagnosis of polyarticular juvenile idiopathic arthritis (PJIA) in the last 730 days?

- ◯ Yes
  (Go to #11)
- ◯ No (Deny)
  (Go to #9)

9. Is the member greater than or equal to (≥) 18 years of age?

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #10)

10. Is the member greater than or equal to (≥) four (4) years of age?

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #11)

11. Is the member greater than or equal to (≥) two (2) years of age?

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

12. Does the member have a history of heart failure in the last 365 days?

- ◯ Yes (Deny)
  (Go to #13)
- ◯ No
  (Go to #13)

13. Does the member have a history of demyelinating disease (multiple sclerosis, optic neuritis and/or Guillain -Barre syndrome) in the last 365 days?

- ◯ Yes (Deny)
  (Go to #14)
- ◯ No
  (Go to #14)

14. Does the member have a history of hematologic abnormalities such as aplastic anemia, pancytopenia, thrombocytopenia, neutropenia, or decreased white blood cell counts in the last 180 days?

- ◯ Yes (Deny)
  (Go to #15)
- ◯ No
  (Go to #15)

15. Does the member have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

- ◯ Yes (Deny)
  (Go to #16)
- ◯ No
  (Go to #16)

16. Does the member have one (1) claim for a contraindicated drug in the last 30 days?

Examples of contraindicated drugs include: cyclophosphamide, KINERET, and ORENCIA.

◯ Yes (Deny)
(Go to #17)

◯ No (Approve - 365 days)
(Go to #17)

Additional Information

17. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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