Date _____

RESTAT
PRESCRIPTION BENEFIT MANAGERS

Client _____

PRIOR AUTH QUESTIONNAIRE - ENBREL®

M.D. Last Name: _____ ***M.D. First Name:*** _____

Physician Phone: _____ ***Physician Fax:*** _____

Patient _____ ***ID#*** _____ ***DOB*** _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

PLEASE NOTE: ***FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES***

1. Please indicate patient's diagnosis:
   - ☐ Rheumatoid Arthritis (RA)
   - ☐ Polyarticular course Juvenile Rheumatoid Arthritis (JRA)
   - ☐ Psoriatic Arthritis
   - ☐ Ankylosing spondylitis (AS) (Skip to #7)
   - ☐ Plaque Psoriasis (Skip to #4)
   - ☐ Other* _____

   *Note: If "Other" diagnosis is used, please attach a study with efficacy data supporting this request
2. Is the patient taking or has the patient failed a trial of methotrexate? (if YES, Skip to #7) Yes No
3. If No, list other DMARDs tried and dates used: (skip to #7) _____

   _____
4. Please check if the patient has tried any of the following:
   - ☐ Retinoids
   - ☐ DMARD's (methotrexate)
   - ☐ Immunosuppressants
   - ☐ Phototherapy
5. Body Surface Area affected by plaques: _____ %
6. Are the plaques present on any of the following? ☐ Hands ☐ Feet ☐ Face ☐ Genitals
7. Strength _____ SIG: _____
8. Quantity _____ Duration of Therapy: _____

Physician Signature or name of person providing answers _____

Physician Comments _____

_____

_____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND. WI 53095

QUESTIONS PLEASE CALL:
877-526-9906