



Date _____

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
- Immunosuppressants
- DMARD's (methotrexate)
- 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
11900 W. Lake Park Dr.
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:
877-526-9906