145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

PRIOR AUTHORIZATION PROGRAM FORM
Enbrel® (Etanercept)

Instructions:
1. Section 1 to be completed by Plan Member / Patient
2. Section 2 to be completed by Physician (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist

Please fax completed form to NexgenRx Formulary Management to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario,M8Z-5M4

Section 1: To be completed by Patient

Member's Name: (Last , First)	Card ID Number:		
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Member (please circle) Employee Spouse Dependent	PATIENT CODE

Results of this request to be communicated to:

☐ Pharmacy	☐ Patient / Legal Guardian Named Below	☐ email:

I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

Patient / Legal Guardian Name: ______________________ Telephone Number: ______________

Signature of Patient/ Legal Guardian: ______________________ Date (dd/mm/yy):______________

Section 2: To be completed by Physician

Drug Name & Strength:	DIN:	Dosage Instructions:

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

- ☐ To reduce the signs and symptoms of moderate to severe active rheumatoid arthritis in adult patients and induce a major clinical response, inhibit the progression of structural damage and improve physical function. Enbrel may be used with methotrexate or alone.
- ☐ To reduce the signs and symptoms of moderate to severe polyarticular juvenile idiopathic arthritis in children aged 4-17 who have had an inadequate response to one or more DMARDs.
- ☐ To reduce the signs and symptoms and inhibit progression of structural damage of active arthritic disease in adult patients with psoriatic arthritis. Enbrel can be used with methotrexate in adults who do not respond to methotrexate alone.
- ☐ To treat chronic moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.
- ☐ To reduce the signs and symptoms of active ankylosing spondylitis.

Physician Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Physician:	Date (dd/mm/yy)

Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Pharmacist: ______________________ Pharmacist's Name: (Print Last, First) ______________________	

Internal Office Use Only:

Date Received:	DIN Number:	HICL:	Date Approved: