



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:	<table border="1" style="width: 100%; height: 15px;"> <tr> <td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td> </tr> </table>																	<table border="1" style="width: 100%; height: 15px;"> <tr> <td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td><td style="width: 5%;"></td> </tr> </table>																	
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Member (please circle)			PATIENT CODE																															
		Employee	Spouse	Dependent																																

Results of this request to be communicated to:

<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Patient / Legal Guardian Named Below	<input type="checkbox"/> email:
<p>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.</p>		
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: 02242903 02274728	Dosage Instructions:
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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 one of the following qualifying criteria for drug coverage:

- Treatment of moderately to severely active rheumatoid arthritis in adults. Treatment is effective in reducing the signs and symptoms of RA, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function. Enbrel can be initiated in combination with methotrexate (MTX) in adult patients or used alone.
- Reducing the signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis (IA) in patients aged 4 to 17 years who have had an inadequate response to one or more disease-modifying antirheumatic drugs (DMARDs). Enbrel has not been studied in children less than 2 years of age.
- Reducing signs and symptoms, inhibiting the progression of structural damage of active arthritis and improving physical function in adult patients with psoriatic arthritis (PsA). Enbrel can be used in combination with methotrexate in adult patients who did not respond adequately to methotrexate alone.
- Reducing signs and symptoms of active ankylosing spondylitis (AS).
- Treatment of adult patients with chronic moderate to severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy.
- Treatment of pediatric patients ages 4 to 17 years with chronic severe PsO who are candidates for systemic therapy or phototherapy. Data on safety and efficacy are limited in the age group 4 to 6 years.

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:			Date Approved & By:
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