Enbrel® (etanercept)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:

If Applicable: Pharmacy Name: ____________________
Pharmacy Phone: ____________________

STEP 2

Complete the Clinical Assessment:

Diagnosis	☐ Moderate to severe active Rheumatoid Arthritis	☐ Severe plaque psoriasis
	☐ Psoriatic Arthritis	☐ Other (please state):
	☐ Ankylosing spondylitis	
Physician Specialty	☐ Rheumatology	☐ Other (please state):
	☐ Physician experienced with Etanercept therapy	
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Enbrel® (etanercept) Strength ____________ Sig ____________ Qty ____________ Refills ____________	
	Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

____________________ ____________________
Prescriber Signature Date

Prior

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Pharmacy Technician initials ______ Date Initiated ____________

Confidentiality Notice:

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