29428

KANSAS MEDICAID
PRIOR AUTHORIZATION
Etanercept (Enbrel®)

Request Date ___ / ___ / ____

BENEFICIARY INFORMATION

Beneficiary Medicaid ID Number

Beneficiary Date of Birth ___ / ___ / ____

Beneficiary Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State

Zip Code -

Prescriber Phone: - -

Prescriber Fax: - -

Prescriber Medicaid ID #

Prescriber NPI #

NDC Requested:

Strength _____ Quantity _____ Length of Therapy on Prescription _____

OR - Procedure Code requested: _____ Total # of units requested per 6 months: _____

Prescription instructions(sig):_____

1. Please indicate the diagnosis and severity for which Enbrel® is being prescribed (no dx codes):

_____

_____

2. Prescribed by a Rheumatologist? Yes _____ No _____

3. Prescribed by a Dermatologist? Yes _____ No _____

4. For Plaque Psoriasis, is client candidate for systemic therapy or phototherapy? Therapy tried:

_____

_____

_____

5. TB skin test results: Date: ___/___/_____ Positive _____ Negative _____

Signature of Prescriber_____ Date ___ / ___ / ____

*Prescriber signature mandatory

FAX TO: **KANSAS Medicaid Prior Authorizations**

Fax: (866) 246-8512

PA HELPDESK: (877) 475 - 7567

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August 2011