Mass General Brigham
Health Plan

Enbrel (etanercept)
Effective 01/01/2026

Plan	☐ MassHealth UPPL ☒ Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview
Enbrel (etanercept) is a tumor necrosis factor (TNF) blocker indicated for the treatment of: adults with:

- Rheumatoid arthritis
- Psoriatic arthritis
- Ankylosing spondylitis
- Plaque psoriasis

It is also approved in pediatric patients with:

- Polyarticular juvenile idiopathic arthritis (pJIA), 2 years of age and older
- Juvenile psoriatic arthritis, 2 years of age and older
- Plaque psoriasis, 4 years of age and older

Coverage Guidelines
Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted when all the following diagnosis-specific criteria are met:

Moderately to severely active rheumatoid arthritis (RA)

1. Diagnosis of moderately to severely active rheumatoid arthritis
2. Member has a minimum duration of 3-month trial and failure, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses:
    a. Methotrexate
    b. Leflunomide
    c. Sulfasalazine

Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)

1. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)

2. Member has a minimum duration of 6-week trial and failure, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses
    a. Leflunomide
    b. Methotrexate

Active psoriatic arthritis (PsA)

1. Diagnosis of active psoriatic arthritis
2. Member meets ONE of the following:
    a. Actively inflamed joints
    b. Dactylitis
    c. Enthesitis
    d. Axial disease
    e. Active skin and/or nail involvement

Active ankylosing spondylitis (AS)

1. Diagnosis of active ankylosing spondylitis
2. Member has minimum duration of 1-month trial and failure, contraindication, or intolerance to TWO different non-steroidal anti-inflammatory drugs (NSAIDs) at maximally tolerated doses.

Moderate to severe chronic plaque psoriasis (PsO)

1. Diagnosis of moderate to severe chronic plaque psoriasis
2. At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected
3. Member meets ONE of the following criteria:
    a. Minimum duration of 4-week trial and failure, contraindication, or intolerance to ONE of the following topical therapies
        I. Corticosteroids (e.g., betamethasone, clobetasol)
        II. Vitamin D analogs (e.g., calcitriol, calcipotriene)
        III. Tazarotene
        IV. Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
        V. Anthralin
        VI. Coal tar
    b. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

<u>Continuation of Therapy</u>

Requests for reauthorizations for all diagnoses will be granted when the following criteria are met:

1. Documentation is submitted supporting improvement in member's condition as evidenced by low disease activity or improvement in signs and symptoms of the condition.

Limitations

1. Approvals will be granted for 24 months.
2. The following quantity limitations apply:

Drug Name and Dosage Form	Quantity Limit
Enbrel cartridge	4 cartridges per 28 days
Enbrel autoinjector	4 cartridges per 28 days
Enbrel prefilled syringe	4 syringes per 28 days

References

1. Elmets CA, Korman NJ, Farley Prater E, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. J Am Acad Dermatol 2021;84:432-70.
2. Enbrel (etanercept) [prescribing Information]. Thousand Oaks, CA: Amgen; October 2023.
3. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. 2021;73(7):924-939.
4. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol 2019;80:1029-72.
5. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. Arthritis Rheumatol. 2019;71(6):846-863.
6. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation guideline for the treatment of psoriatic arthritis. Arthritis Rheumatol. 2019;71(1):5-32.
7. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care Res. 2015;68(1):1-25.
8. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/spondyloarthritis research and treatment network recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. Arthritis Rheumatol. 2019;71(10):1599-1613.

Review History

03/21/2005 – Reviewed
05/15/2005 – Effective
02/27/2006 – Reviewed
02/25/2008 – Reviewed
02/23/2009 – Reviewed
02/22/2010 – Reviewed
02/28/2011 – Reviewed
02/27/2012 – Reviewed
02/25/2013 – Reviewed
02/24/2014 – Reviewed
02/23/2015 – Reviewed
02/22/2016 – Reviewed
02/2017 – Reviewed (switched to SGM)
02/26/2018 – Reviewed (switched to Custom) in P&T Meeting
02/20/2019 – Reviewed
07/22/2020 – Reviewed and updated July P&T Mtg; reworded overview; removed compendial use of reactive arthritis; changed diagnosis of axial spondyloarthritis to nonradiographic axial spondyloarthritis. Effective 10/01/2020.
11/15/2023 – Reviewed and Updated for November P&T; removed TB requirement. Added additional treatment options for conventional therapies for Rheumatoid arthritis. Added additional treatment options for 6-week treatment for PJIA. Psoriatic arthritis – removed conventional therapies and added member meets one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis – changed from 5% BSA to 3% BSA. Removed appendix with contraindications to methotrexate. Consolidated conventional therapies for plaque psoriasis. Removed Appendix. Effective 1/1/24.
10/09/2024 – Reviewed and updated for October P&T. Updated reauthorization criteria language to be consistent with other immunomodulators. Effective 1/1/2025.

12/11/2024 – Reviewed and updated for December P&T. Removed diagnosis of nonradiographic axial spondyloarthritis. Effective 3/1/2025.
06/11/2025 – Reviewed and updated for June P&T. Updated Limitations section to include quantity limits. Effective 07/01/2025.
10/08/2025 – Reviewed and updated at October P&T. Minor verbiage updates to trial language for ankylosing spondylitis; intent remains the same. Effective 01/01/2026.