

**Enbrel (etanercept)**  
**Effective 08/16/2026**

|                              |                                                                                                      |                                            |                                                                                  |
|------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------|
| <b>Plan</b>                  | <input type="checkbox"/> MassHealth UPPL<br><input checked="" type="checkbox"/> Commercial/Exchange  | <b>Program Type</b>                        | <input checked="" type="checkbox"/> Prior Authorization                          |
| <b>Benefit</b>               | <input checked="" type="checkbox"/> Pharmacy Benefit<br><input type="checkbox"/> Medical Benefit     |                                            | <input type="checkbox"/> Quantity Limit<br><input type="checkbox"/> Step Therapy |
| <b>Specialty Limitations</b> | This medication has been designated specialty and must be filled at a contracted specialty pharmacy. |                                            |                                                                                  |
| <b>Contact Information</b>   | <b>Medical Benefit</b><br><b>Pharmacy Benefit</b>                                                    | Phone: 833-895-2611<br>Phone: 800-711-4555 | Fax: 888-656-6671<br>Fax: 844-403-1029                                           |
| <b>Exceptions</b>            | N/A                                                                                                  |                                            |                                                                                  |

### Overview

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

- Moderately to severely active rheumatoid arthritis
- Active psoriatic arthritis
- Active ankylosing spondylitis
- Chronic moderate to severe plaque psoriasis

It is also approved in pediatric patients with:

- Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA), 2 years of age and older
- Active juvenile psoriatic arthritis, 2 years of age and older
- Chronic moderate to severe plaque psoriasis, 4 years of age and older

### Coverage Guidelines

If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

**OR**

Authorization may be granted when all of the following diagnosis-specific criteria are met:

#### Moderately to severely active rheumatoid arthritis (RA)

1. Diagnosis of moderately to severely active rheumatoid arthritis
2. 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. 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. Minimum duration of 1-month trial and failure, contraindication, or intolerance to TWO different non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen) 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 or targeted synthetic therapy as first-line therapy.

**Continuation of Therapy**

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

1. Submission of medical records (e.g., chart notes) documenting an improvement in member's condition, as evidenced by low disease activity or improvement in signs and symptoms of the condition.

**Limitations**

1. Initial approvals and reauthorizations will be granted for 24 months.
2. The following quantity limitations apply:

| Drug Name and Dosage Form    | Quantity Limit              |
|------------------------------|-----------------------------|
| Enbrel cartridge 50 mg/mL    | 4 cartridges per 28 days    |
| Enbrel autoinjector 50 mg/mL | 4 autoinjectors per 28 days |



|                                       |                        |
|---------------------------------------|------------------------|
| Enbrel prefilled syringe 50 mg/mL     | 4 syringes per 28 days |
| Enbrel prefilled syringe 25 mg/0.5 mL | 8 syringes per 28 days |
| Enbrel vial 25 mg/0.5 mL              | 8 vials 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. 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.

03/11/2026 – Reviewed and updated for March P&T. Administrative update - changing verbiage in reauthorization criteria from “documentation is submitted” to “submission of medical records (e.g., chart notes...” and updating language for members who are new to the Plan. Effective 05/01/2026.

04/15/2026 - Updated previous trial language for plaque psoriasis, allowing for bypassing conventional therapy if member has severe psoriasis that warrants a biologic DMARD or targeted synthetic therapy as first-line therapy. Effective 08/16/2026.

