

# Pharmacy

## PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

 This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

Medicare: PA required for SQ formulation, Part D

# Orencia<sup>®</sup> (abatacept)

 **URGENT** (life threatening)

 **Non-Urgent** (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

### Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

### Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

 \_\_\_\_\_  
 Provider Signature

 \_\_\_\_\_  
 Date

### PRODUCT INFORMATION

- 
- Orencia 250 mg/15 mL intravenous infusion
- 
- 
- Orencia 125 mg/mL subcutaneous injection

**Dose:** \_\_\_\_\_

**Start Date:** \_\_\_\_\_

**Patient's weight:** \_\_\_\_\_

### BILLING INFORMATION

#### Place of administration:

- 
- Self-administered (subcutaneous injection only)
- 
- 
- Provider's Office
- 
- 
- Outpatient Infusion Center
- 
- Center Name: \_\_\_\_\_
- 
- 
- Home Infusion
- 
- Agency Name: \_\_\_\_\_

#### Billing Options:

- 
- Physician buy and bill (J0129)
- 
- 
- Preferred Specialty Vendor
- 
- 
- Other: \_\_\_\_\_

#### Request:

- 
- New – Complete Section A
- 
- 
- Continuation – Complete Section B

**PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS**

Authorization for Orencia® (abatacept) requires the following information to certify:

**Patient must have met the following requirements:**

- Diagnosis of rheumatoid arthritis or juvenile rheumatoid arthritis
- Documented therapeutic trial and clinical failure with at least one self-injectable anti-TNF
- Annual documentation of a negative TB test
- Patient must not have moderate to severe heart failure
- Patient must not be receiving Orencia in combination with Enbrel, Humira, Kineret, or Remicade

**For continuation, patient must have met the following requirements:**

- Diagnosis of rheumatoid arthritis or juvenile rheumatoid arthritis
- The patient is compliant in taking the medication as scheduled
- The patient tolerated the medication
- The patient did not experience any severe adverse reactions while taking the medication
- The patient has responded to treatment, as determined by the prescribing physician
- The patient had a negative TB test result in the previous 12 months.

**SECTION A – NEW THERAPY**
**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION**

Authorization for Orencia® (abatacept) requires the following information to certify:

**A. What is the patient's diagnosis?**

- |    |  |                 |
|----|--|-----------------|
| a. | <input type="checkbox"/> juvenile rheumatoid arthritis | ICD code: _____ |
| b. | <input type="checkbox"/> rheumatoid arthritis          | ICD code: _____ |
| c. | <input type="checkbox"/> Other: _____                  | ICD code: _____ |
- Rationale for use:* \_\_\_\_\_

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

**B. Has the patient had a documented therapeutic trial with at least one self-injectable anti-TNF?**

- |  |                                       |              |                |
|--|---------------------------------------|--------------|----------------|
| <input type="checkbox"/> Yes,                          | <b>Dose</b>                           | <b>Dates</b> | <b>Outcome</b> |
|  | <input type="checkbox"/> Enbrel _____ | _____        | _____          |
|  | <input type="checkbox"/> Humira _____ | _____        | _____          |
| <input type="checkbox"/> No – Rationale for use: _____ |                                       |              |                |

**C. Has the patient had a negative TB test result in the past 12 months?**

- Yes – Date test read: \_\_\_\_\_
- No – Rationale for use: \_\_\_\_\_

**D. Does the patient have moderate to severe heart failure?**

- No
- Yes – Rationale for use: \_\_\_\_\_

**E. Will the patient be using any of the following medications: Enbrel, Humira, Kineret, or Remicade?**

- No
- Yes – Rationale for use: \_\_\_\_\_

## SECTION B – CONTINUATION

to be completed for patient's in which Orenzia® (abatacept) was previously authorized by Priority Health

### PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for continuation of Orenzia® (abatacept) requires the following information to certify:

#### A. What is the patient's diagnosis?

- a.  juvenile rheumatoid arthritis ICD code: \_\_\_\_\_  
b.  rheumatoid arthritis ICD code: \_\_\_\_\_  
c.  Other: \_\_\_\_\_ ICD code: \_\_\_\_\_

Rationale for use: \_\_\_\_\_

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

#### B. Select which of the following apply (all must be met for continuation of therapy):

- The patient is compliant in taking the medication as scheduled  
 The patient tolerated the medication  
 The patient did not experience any severe adverse reactions while taking the medication  
 The patient has responded to treatment, as determined by the prescribing physician  
 The patient had a negative TB test result in the previous 12 months. **Date of test:** \_\_\_\_\_

### OTHER INFORMATION

#### Note:

- Live vaccines should not be given concurrently with Orenzia or within 3 months of its discontinuation.
- Use of Orenzia in patients with rheumatoid arthritis and COPD should be undertaken with caution and such patients should be monitored for worsening of their respiratory status.

### PRIORITY MEDICARE PLANS

**Note:** Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

LCD N/A

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

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**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**