PriorityHealth

Priority Health Medicare Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Orencia® (abatacept) subcutaneous

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____
Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____
Physician Address: _____
Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request
Drug Product ☐ Orencia prefilled syringe
☐ Orencia ClickJect autoinjector

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Before this drug is covered, the patient must meet all the following requirements:

1. Must be used for a medically accepted indication*
2. Must be ≥ 2 years old
3. Must not be used in combination with other biological products (e.g., Humira, Enbrel)
4. Prescriber must be a specialist or has consulted with a specialist for the condition being treated
5. For a diagnosis of psoriatic arthritis or rheumatoid arthritis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to all the following:
   a. One non-biologic immunomodulator (e.g. methotrexate, leflunomide, hydroxychloroquine, sulfasalazine)
   b. Humira or Enbrel

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- –– *or* –– supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and Lexi-Drugs.)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 08/2020
Last reviewed 08/2020

Additional information

Note: When criteria are met, coverage duration is 1 year

Priority Health Precertification Documentation

A. Is the prescriber a specialist or consulted with a specialist for the condition being treated?

- ☐ Yes
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

B. Will Orencia be used in combination with other biological products (e.g., Humira, Enbrel)?

- ☐ No
- ☐ Yes. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

Condition	Additional requirements for specific indications
(Please check the appropriate boxes to indicate the patient has met the required criteria	
☐ Rheumatoid arthritis ☐ Psoriatic arthritis	**1. Has the patient had a documented trial and failure (defined as an inability to improve symptoms) or intolerance to 1 non-biologic immunomodulator?** ☐ Yes. ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No **2. Has the patient had a documented trial and failure (defined as an inability to improve symptoms) or intolerance to Humira or Enbrel?** ☐ Yes. ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No
☐ Other condition	**1. The patient's condition is:** _____ **2. Rationale for use is:** _____

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Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Orencia likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Orencia, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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