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)

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 and Billing Information

☐ New Request ☐ Continuation Request

Drug product:
- ☐ Orencia 250 mg IV injection
- ☐ Orencia 50 mg/0.4 mL SC prefilled syringe
- ☐ Orencia 87.5 mg/0.7 mL SC prefilled syringe
- ☐ Orencia 125 mg/mL SC prefilled syringe
- ☐ Orencia ClickJect 125 mg/mL SC autoinjector

Start date (or date of next dose): ______________________

Date of last dose (if applicable): ______________________

Dose: __________ **Dose Frequency**:______________________

Height: _____________ **Weight**: ______________

Place of administration:
- ☐ Self-administration
- ☐ Physician's office
- ☐ Outpatient infusion
  Facility: ______________________ NPI:______________________ Fax:____________________
- ☐ Home infusion
  Facility: ______________________ NPI:______________________ Fax:____________________

Billing:
- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  Pharmacy:______________________ NPI:______________________ Fax:____________________

ICD-10 Diagnosis code(s): ______________________

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 and the DRUGDEX Information System.)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2019
Last reviewed 01/2019

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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 of the following requirements:

For Orencia subcutaneous formulations:

1. Must be used for a medically-accepted indication*
2. Must have a negative TB test (must be done yearly)
3. Must be $\geq$ 2 years old
4. For Orencia ClickJect Autoinjector: Must try Humira or Enbrel
5. For Orencia subcutaneous prefilled syringes (125mg/ml, 50mg/0.4ml., and 87.5mg/0.7ml): Must first try infliximab**

For Orencia IV injection formulation:

1. Must be $\geq$ 6 years old
2. Must be used for a medically-accepted indication*

****Note**: This requirement only applies to members enrolled in a MAPD (Medicare Advantage Prescription Drug) plan

Additional information

Note: If approved, coverage duration is for 1 year

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Polyarticular juvenile idiopathic arthritis, moderate to severe
- ☐ Rheumatoid arthritis, moderate to severe
- ☐ Psoriatic arthritis
- ☐ Other – the patient's condition is: ____________________
  Rationale for Other use: ____________________

B. What is the date and result of the patient's most recent TB test *(for Orencia subcutaneous formulations only)***?**

- ☐ Negative **Date:** ____________________
- ☐ Positive
- ☐ Not completed. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: ____________________
  - ☐ No

C. Has the patient tried Enbrel or Humira *(for Orencia ClickJect Autoinjector users only)***?**

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

D. Has the patient tried infliximab *(for Orencia 125mg/ml, 50mg/0.4ml, 87.5mg/0.7ml prefilled syringes only)***?**

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

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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: ______________________________

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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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Last reviewed 01/2019