

# Pharmacy Prior Authorization Form

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

This form applies to:  **Commercial (Traditional)**     **Commercial (Individual/Optimized)**

**Medicaid**

This request is:  **Urgent** (life threatening)     **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

## Orencia<sup>®</sup> (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/15 mL IV infusion    **Dose:** \_\_\_\_\_ **Dose Frequency:** \_\_\_\_\_  
 Orencia 50 mg/0.4 mL SC injection    **Start date:** \_\_\_\_\_  
 Orencia 87.5 mg/0.7 mL SC injection    **Date of last dose:** \_\_\_\_\_  
 Orencia 125 mg/mL SC injection    **Date of next dose:** \_\_\_\_\_  
 Orencia ClickJect 125 mg/mL SC autoinjector    **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

Administration:     Patient to self-inject  
 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): \_\_\_\_\_

### ORENCIA COVERAGE POLICY

- Before Orencia is covered, the patient must meet all of the General Criteria for Orencia and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Orencia will not be covered in combination with another biologic.

- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

**Criteria**

**General Criteria for ALL Diagnoses:**

- a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND
- b) Prescriber is a specialist or has consulted with a specialist for the disease being treated.

**Specific Criteria for Individual Diagnoses:**

1. Rheumatoid Arthritis

- a) Patient has tried at least ONE conventional synthetic DMARD (such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) for a period of at least 3 months; AND
- b) Patient has tried TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR, each for a period of at least 3 months.

2. Juvenile Idiopathic Arthritis

- a) Patient has tried Enbrel or Humira for a period of at least 3 months.

3. Psoriatic Arthritis

- a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, sulfasalazine or azathioprine) for a period of at least 3 months; AND
- b) Patient has tried TWO of the following: Cosentyx, Enbrel, Humira, Xeljanz/XR, or Stelara SC, each for a period of at least 3 months.

**Note:** Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

---

**Priority Health Precertification Documentation**

**A. What condition is this drug being requested for?**

- Rheumatoid arthritis
  - Juvenile idiopathic arthritis
  - Psoriatic Arthritis
  - Other – the patient’s condition is: \_\_\_\_\_
- Rationale for use: \_\_\_\_\_

**B. Which of the following has the patient had a documented therapeutic trial with?**

- Methotrexate      Dates of therapy: \_\_\_\_\_
- Leflunomide      Dates of therapy: \_\_\_\_\_
- Hydroxychloroquine      Dates of therapy: \_\_\_\_\_
- Sulfasalazine      Dates of therapy: \_\_\_\_\_
- Azathioprine      Dates of therapy: \_\_\_\_\_
- Actemra      Dates of therapy: \_\_\_\_\_
- Enbrel      Dates of therapy: \_\_\_\_\_
- Humira      Dates of therapy: \_\_\_\_\_
- Xeljanz/XR      Dates of therapy: \_\_\_\_\_
- Cosentyx      Dates of therapy: \_\_\_\_\_
- Stelara      Dates of therapy: \_\_\_\_\_
- Other      Drug: \_\_\_\_\_      Dates of therapy: \_\_\_\_\_

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

- Yes      Date: \_\_\_\_\_
- No, rationale for use: \_\_\_\_\_

**D. Will the patient be receiving other biologic therapy in combination with Orencia?**

- No     Yes, rationale for use: \_\_\_\_\_