univera HEALTHCARE

Orencia® (abatacept)
Intravenous (IV)
RA, JIA, & PsA
Medical Benefit

Specialty Medication Review Program

Complete this form and fax to:

☐ Medical **(Office Admin)**
Fax #: 1-800-306-0188
Phone #: 1-800-499-1275

Indicate how the healthcare provider will obtain the medication:

☐ **Buy and Bill**

☐ **Accredo Health**
Fax: 1-888-773-7386
Phone: 1-866-413-4137

☐ **Walgreens Specialty Pharmacy**
Fax: 1-866-435-2173
Phone: 1-866-435-2171

Complete ALL the following Patient/Prescriber information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Location of Infusion:
☐ **Prescriber office** ☐ **Home/Homecare agency:**_____
☐ **Outpatient facility** ☐ **Other:** _____

Servicing Prescriber NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

Medication/Medical and Dispensing Information

Medication (HCPCS)	**Dose**	**Frequency**
Orencia IV vial (J0129)	☐ 500mg if less than 60kg ☐ 750mg if between 60kg to 100kg ☐ 1000mg if greater than 100kg	

Diagnosis/ICD-10:

Is this request for a: ☐ New Start **OR** ☐ Continuation of Therapy (recertification)?

☐ **New Start**: IV loading dose on day 0, and then ongoing IV as **health care professional administered**.

☐ **Continuation of Therapy**: IV **health care professional-administered** dosing only

☐ **Continuation of Therapy**: SQ **self-administered** dosing only ***Please use SQ Therapy PA Form***

☐ **New Start**: IV loading dose on day 0, and then ongoing SQ as **self-administered.** ***Please use SQ Therapy PA Form***

Questions/Indications for Medical Necessity

**** See the Inflammatory CRPA Policy (Pharmacy-73) for full Prior Authorization criteria ****

***Please note:** *Combination therapy of Orencia with any other biologic therapy will not be approved.*

***Note:** Patients will be approved for a single loading dose under the medical benefit, and then approval will be loaded for the SQ dosage to be obtained under the pharmacy benefit if self-administered or for the IV dosage to be given under the medical benefit if health care professional administered.

Select one of the following diagnoses:

☐ Rheumatoid Arthritis
☐ Juvenile Idiopathic Arthritis
☐ Psoriatic Arthritis
☐ Other: _____

1. Is the prescribing physician a Rheumatologist? ☐ Yes ☐ No

2. Has this patient had a failure of a 12-week course of one of the following DMARDs? **(select all that apply)**
☐ methotrexate ☐ azathioprine ☐ sulfasalazine ☐ hydroxychloroquine ☐ Other:_____

3. Has this patient had serious side effects or drug failure with the following biologics? **(select all that apply)**
☐ Inflectra/Avsola ☐ Simponi Aria ☐ Stelara ☐ Tremfya Other: _____

4. **If continued IV therapy** is needed, *provide clinical rationale for IV (i.e., rationale for no SQ route):

***ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.**

***Prescriber Signature:** _____ **Date:** _____

I certify the above is true and accurate to the best of my knowledge