aetna®

Orencia® (abatacept) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916
IV Formulation only:
Phone: 1-866-503-0857
Fax: 1-888-267-3277
For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment, **Start Date:** ____/____/____ ☐ Continuation of therapy, date of last treatment: ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Rheumatologist** ☐ **Other**:

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Orencia: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For Initiation Requests

☐ Yes ☐ No Will Orencia be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?
☐ Yes ☐ No Does the patient have a documented TB test within 6 months of initiating a biologic therapy?
(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
→ Please enter the date and results of the TB test: Date: ____/____/____ Results: ☐ Positive ☐ Negative ☐ Unknown
If positive, does the patient have latent or active TB? ☐ Latent ☐ Active
If latent TB, ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with abatacept (Orencia)?

For Juvenile Idiopathic Arthritis

Please indicate the severity of the patient's condition: ☐ Mild ☐ Moderate ☐ Severe
☐ Yes ☐ No Is this request for subcutaneous or intravenous? ☐ Subcutaneous ☐ Intravenous
☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Has the patient had an ineffective response to Enbrel?
→ Please provide date range: ____/____/____ to ____/____/____
☐ Yes ☐ No Does the patient have a documented intolerance Enbrel?
☐ Yes ☐ No Does the patient have a documented contraindication Enbrel?

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G. CLINICAL INFORMATION (*continued*) – Required clinical information must be completed in its entirety for all precertification requests.

Psoriatic Arthritis

☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?
→ ☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Has the patient had an ineffective response to at least **TWO (NSAIDs**)? Provide the names and date ranges:
NSAID #1: _____ Date range: ___/___/___ to ___/___/___
NSAID #2: _____ Date range: ___/___/___ to ___/___/___

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?
→ ☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Was the treatment with methotrexate ineffective? ***If yes***, Date range: ___/___/___ to ___/___/___
☐ Yes ☐ No Was the treatment with methotrexate not tolerated or contraindicated?
☐ Not tolerated ☐ Contraindicated
→ ☐ Yes ☐ No Has the patient had an ineffective response to at least 1 (other than methotrexate) conventional (DMARD)?
Provide the name and date range: Name: _____ Date range: ___/___/___

☐ Yes ☐ No Was treatment with **Enbrel** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Enbrel not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Otezla** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Otezla not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Inflectra** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Inflectra not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Remicade** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Remicade not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Renflexis** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Renflexis not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Simponi** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Simponi not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Stelara** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Stelara not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

For Rheumatoid Arthritis

Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe
☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Was treatment with **Enbrel** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Enbrel not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Inflectra** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Inflectra not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Remicade** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Remicade not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Renflexis** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Renflexis not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Simponi** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Simponi not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Simponi Aria** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Simponi Aria not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with **Xeljanz/Xeljanz XR** ineffective?
Please provide the date range of the trial: Date range: ___/___/___ - ___/___/___
☐ Yes ☐ No Was the treatment with Xeljanz/Xeljanz XR not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

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G. CLINICAL INFORMATION (*continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Continuation Requests

☐ Yes ☐ No Will Orencia be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Has the patient received samples of abatacept (Orencia)? (Sampling of Orencia does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Is there clinical documentation of disease stability or improvement? ☐ Disease stability ☐ Improvement

☐ Yes ☐ No Does the patient have any risk factors for TB?

→ ☐ Yes ☐ No Has the patient had a TB test within the past 12 months?
(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the date and results of the TB test: Date: ____/____/____
Results: ☐ Positive ☐ Negative ☐ Unknown

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests