



MEDICARE FORM

Orencia® (abatacept) Injectable Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:

Please use other form.

Note: Orencia is non-preferred. Preferred products may vary based on indication. See section G below.

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 #:		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Group #:		If yes, provide ID#:		Carrier Name:	
Insured:		Insured:			
C. PRESCRIBER INFORMATION					
First Name:		Last Name: (Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	
D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION					
Place of Administration:			Dispensing Provider/Pharmacy:		
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office			<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy		
<input type="checkbox"/> Outpatient Infusion Center Phone: _____			<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order		
Center Name: _____			<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Home Infusion Center Phone: _____			Name: _____		
Agency Name: _____			Address: _____		
<input type="checkbox"/> Administration code(s) (CPT): _____			City: _____ State: _____ ZIP: _____		
Address: _____			Phone: _____ Fax: _____		
City: _____ State: _____ ZIP: _____			TIN: _____ PIN: _____		
Phone: _____ Fax: _____			NPI: _____		
TIN: _____ PIN: _____					
NPI: _____					
Please explain if there are any medical reason(s) why the patient cannot self-inject the requested drug:					
E. PRODUCT INFORMATION					
Request is for: Orencia (abatacept):					
Dose: _____ Frequency: _____					
HCPCS Code: _____ <input type="checkbox"/> IV <input type="checkbox"/> SC					
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 (clinical documentation required):					
<input type="checkbox"/> Yes <input type="checkbox"/> No Will Orencia (abatacept) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?					
→ (Check all that apply): <input type="checkbox"/> PPD test <input type="checkbox"/> interferon-gamma assay (IGRA) <input type="checkbox"/> chest x-ray					
Please enter the results of the TB test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown					
If positive, Does the patient have latent or active TB? <input type="checkbox"/> Latent <input type="checkbox"/> Active					
If latent TB, <input type="checkbox"/> Yes <input type="checkbox"/> No Will TB treatment be started before initiation of therapy with Orencia (abatacept)?					
Note: Orencia is non-preferred. Avsola, Remicade, and Simponi Aria are preferred for MA plans. Enbrel, Humira, Rinvoq, and Xeljanz/Xeljanz XR are preferred for MAPD plans. Preferred products may vary based on indication.					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior therapy with Orencia (abatacept) within the last 365 days?					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)					
<input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Avsola (infliximab-axxq) <input type="checkbox"/> Simponi Aria (golimumab)					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)					
<input type="checkbox"/> Enbrel (etanercept) <input type="checkbox"/> Humira (adalimumab) <input type="checkbox"/> Rinvoq (upadacitinib) <input type="checkbox"/> Xeljanz/Xeljanz XR (tofacitinib)					
Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply).					
<input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Avsola (infliximab-axxq) <input type="checkbox"/> Simponi Aria (golimumab)					

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)

- Enbrel (etanercept) Humira (adalimumab) Rinvoq (upadacitinib) Xeljanz/Xeljanz XR (tofacitinib)

Juvenile idiopathic arthritis (juvenile rheumatoid arthritis)

Please indicate the severity of the patient's disease: Mild Moderate Severe

Yes No Is there evidence that the disease is active?

Yes No Has the patient had an ineffective response to Enbrel (etanercept)?

→ Yes No Was treatment with Enbrel (etanercept) not tolerated or contraindicated?

Please select: not tolerated contraindicated

Psoriatic Arthritis

Yes No Is there evidence that the disease is active?

Yes No Does the patient have **axial** psoriatic arthritis?

→ Yes No Was the treatment with 2 or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?

→ Please provide the names of treatment:

NSAID #1: _____

NSAID #2: _____

Yes No Does the patient have **non-axial** psoriatic arthritis?

→ Yes No Was treatment with methotrexate ineffective?

→ Yes No Was treatment with methotrexate not tolerated or contraindicated?

→ Please select: not tolerated contraindicated

Yes No Was a trial with a conventional disease-modifying anti-rheumatic drug ineffective?

→ Please select: cyclophosphamide cyclosporine hydroxychloroquine

leflunomide sulfasalazine

Other: Please explain: _____

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 methotrexate ineffective?

→ Yes No Was treatment with methotrexate not tolerated or contraindicated?

→ Please select: not tolerated contraindicated

Yes No Was treatment with another conventional DMARD (other than methotrexate) ineffective?

→ Provide select: azathioprine hydroxychloroquine leflunomide sulfasalazine

For Continuation requests (clinical documentation required):

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

Please indicate the severity of the patient's disease at baseline (pretreatment with Orencia (abatacept)): Mild Moderate Severe

Yes No Is there clinical documentation supporting disease stability?

Yes No Is there clinical documentation supporting disease improvement?

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

→ Yes No Has the patient had a TB test within the past year?

(check all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray

Please the results of the TB test: Positive Negative Unknown

Yes No Is this continuation request a result of the patient receiving samples of Orencia (abatacept)?

For Juvenile idiopathic arthritis (juvenile rheumatoid arthritis) IV formulation only (continuation of therapy requests only):

Yes No Has the patient received Orencia (abatacept) within the past 6 months?

→ Yes No Does the patient have a documented severe and/or potentially life-threatening adverse event that occurred during or following the previous infusion?

→ Yes No Could the adverse reaction be managed through pre-medication in the home or office setting?

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