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 #: _____
Group #: _____
Insured:

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

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:
Office Contact Name:			Phone:		

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: _____

Please explain if there are any medical reason(s) why the patient cannot self-inject the requested drug:

_____

_____

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

E. PRODUCT INFORMATION

Request is for: Orencia (abatacept):
Dose: _____ **Frequency:** _____
HCPCS Code: _____ ☐ IV ☐ 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):

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

☐ Yes ☐ 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): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ 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 Orencia (abatacept)?

Note: Orencia is non-preferred. Remicade, Renflexis, and Simponi Aria are preferred for MA plans. Enbrel, Humira, Rinvoq, and Xeljanz are preferred for MAPD plans. Preferred products may vary based on indication.

☐ Yes ☐ No Has the patient had prior therapy with Orencia (abatacept) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)
☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simponi Aria (golimumab)

☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Rinvoq (upadacitinib) ☐ Xeljanz (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).
☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simponi Aria (golimumab)

_____

_____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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 (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