



MEDICARE FORM

Orencia® (abatacept) Injectable Medication Precertification Request

Page 1 of 3

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

For Virginia HMO SNP:
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

Note: Orencia is non preferred.
Renflexis is preferred for MA
products and Humira is preferred
for MAPD plans.

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:		UPIN:	
St Lic #:		NPI #:		DEA #:	
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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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: _____ 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)?

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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 Renflexis (infliximab-abda)?

Yes No Has the patient had a trial, intolerance, or contraindication to Humira (adalimumab)?

Please explain if there are any other medical reason(s) that the patient cannot use Renflexis (infliximab-abda).

Please explain if there are any other medical reason(s) that the patient cannot use Humira (adalimumab).

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

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

→ Please indicate the length of treatment: Less than 1 month 1 month 2 months 3 months or greater

For IV formulation only:

Yes No Is this infusion request in an outpatient hospital setting?

→ Yes No Is the patient medically unstable for infusions at alternate levels of care?

Yes No Does the patient have a history of any cardiopulmonary conditions?

→ Please provide the description of the condition: _____

Yes No Does this condition cause an increased risk of severe adverse reactions?

Yes No Does the patient have documentation of unstable vascular access?

Yes No Does the patient have physical or cognitive impairments such that home infusion would present an unnecessary health risk?

→ Please explain: _____

Yes No Is there clinical evidence that the patient has an inability to safely tolerate intravenous volume load (including from unstable renal function)?

→ Yes No Is the inability to tolerate intravenous volume load due to unstable renal function?

Please document the following: GFR: _____ mL/min/1.73m² Date Collected: ____/____/____

BUN: _____ mg/dL Date Collected: ____/____/____

Creatinine: _____ mg/dL Date Collected: ____/____/____

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 and length of treatment:

NSAID #1: _____

Please indicate length of treatment: Less than 1 month 1 month 2 months 3 months or greater

NSAID #2: _____

Please indicate length of treatment: Less than 1 month 1 month 2 months 3 months or greater

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: _____

Please indicate length of treatment: Less than 1 month 1 month

2 months 3 months or greater

→ Please indicate the length of treatment: Less than 1 month 1 month 2 months 3 months or greater

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

Please indicate the length of the DMARD treatment: Less than 1 month 1 month

2 months 3 months or greater

→ Please indicate the length of the methotrexate therapy: Less than 1 month 1 month 2 months 3 months or greater

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

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