pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ORENCIA (abatacept) [non-preferred] PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested: Orencia	Route of administration: ☐IV ☐SC ☐vial ☐syringe ☐clickject ☐_____		Strength:
Directions:	Quantity:	Refills:	Beneficiary's weight: _____ lbs/kg
Diagnosis (*submit documentation*):			Diagnosis code (*required*):

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty

INITIAL requests

1. ***All diagnoses***: Check all that apply to the beneficiary and *submit documentation for each*.
   ☐vaccinated for hepatitis B ☐screened for hepatitis B (surface antigen & core antibody) ☐has been using Orencia in the past 90 days
   ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations

2. ***Rheumatoid arthritis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
3. ***Rheumatoid arthritis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Humira ☐Xeljanz	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
4. ***Psoriatic arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐four-week trial each of at least 2 different NSAIDs ☐eight-week trial of methotrexate or other DMARD *(does not apply to axial disease)*	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
5. ***Psoriatic arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira ☐Xeljanz	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
6. ***Juvenile idiopathic arthritis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agent, **Humira**?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
7. ***For all other diagnoses***, submit documentation supporting the use of Orencia for the beneficiary's diagnosis & other treatments tried.		

RENEWAL requests

1. Since starting Orencia, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No	*Submit documentation of clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: