Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Orencia (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Orencia (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Orencia (abatacept)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized Orencia in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 3.]

2. Has the patient had at least 20% improvement in symptoms since starting Orencia? Y N

   [No further questions.]

3. Does the patient have a diagnosis of rheumatoid arthritis (RA) with moderate to high disease activity? Y N

[If no, skip to question 9.]

4. Has the patient had failure to an adequate trial (3 months) of two disease modifying anti-rheumatic drugs (DMARDs) regimens (one must be methotrexate)? Y N

   If yes, list medications tried: _____

   Note: Monotherapy regimen: methotrexate (MTX), hydroxychloroquine (HCQ), leflunomide (LEF), sulfasalazine (SSZ).

   Combination regimen: MTX+SSZ+HCQ; MTX+HCQ, MTX+LEF, MTX+SSZ, SSZ+HCQ

   [If yes, skip to question 6.]

5. Does the patient have a contraindication to methotrexate? Y N

   Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

   If yes, please document contraindication:_____

   [If no, then no further questions]

6. Has the patient had a trial and failure of at least one formulary anti-TNF? Y N

   Please list agent tried:_____

   [If yes, skip to question 8.]

7. Does the patient have CHF (NYHA class III or IV)? Y N

   [If no, then no further questions.]

8. Is the patient 18 years of age or older? Y N

   [If yes, skip to question 21.]

   [If no, then no further questions.]

9. Does the patient have a diagnosis of juvenile idiopathic arthritis (JIA)? Y N

   [If no, no further questions.]

10. Does the patient have the systemic subtype of JIA? Y N

[If no, skip to question 14.]

11. Does the patient currently have any ACTIVE systemic features? Y N

    Note: Systemic features such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis.

    If yes, please list:_____

    [If yes, then no further questions.]

12. Does the patient continue to have synovitis in at least 1 joint despite 3 months of treatment with methotrexate or leflunomide? Y N

    [If yes, skip to question 17.]

13. Does the patient have contraindications to methotrexate and leflunomide? Y N

    Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

    If yes, please document contraindication:_____

    [If no, then no further questions]

    [If yes, skip to question 17.]

14. Does the patient have severe or moderate to severe polyarticular juvenile idiopathic arthritis (pJIA)? Y N

    [If no, then no further questions.]

15. Has the patient had failure to an adequate trial (3 months) of methotrexate? Y N

    [If yes, skip to question 17.]

16. Does the patient have a contraindication to methotrexate? Y N

    Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

    If yes, please document contraindication:_____

    [If no, then no further questions]

17. Is the patient at least 6 years of age? Y N

    [If no, then no further questions]

18. Has the patient had a trial and failure of at least one formulary anti-TNF? Y N

    Please list agent tried:_____

    [If no, then no further questions.]

19. Is the request for the IV formulation of Orencia? Y N

    [If no, no further questions.]

20. Is the patient 6 years of age or older? Y N

    [If no, no further questions.]

21. Is Orencia prescribed by or in consultation with a rheumatologist? Y N

    [If no, no further questions.]

22. Has the patient been screened for latent tuberculosis (TB) and hepatitis B? Y N

    [If no, then no further questions.]

23. Does the patient have an active infection (including Hepatitis B and/or tuberculosis (TB)? Y N

    [If no, skip to question 25.]

24. Is the patient currently receiving or has completed treatment for latent TB infection or Hepatitis B? Y N

    [If no, then no further questions.]

25. Will Orencia be given in combination with another biologic DMARD? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date