04/18/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Orencia (IL88)

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 Medicaid at 1-855-684-5250.
Please contact Aetna Better Health Illinois Medicaid at 1-866-212-2851 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Orencia (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Orencia (abatacept)

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: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of rheumatoid arthritis? Y N

   [If no, skip to question 5.]

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

   [If no, no further questions.]

3. Does the patient meet ONE of the following? Please indicate which of the below apply to patient: Y N

   _____

Trial and failure of a compliant regimen of methotrexate in combination with sulfasalazine, hydroxychloroquine or leflunomide for at least 3 months OR \ Trial and failure of monotherapy with methotrexate for at least 3 months and trial and failure of monotherapy with sulfasalazine, hydroxychloroquine or leflunomide for at least 3 months.

[If no, no further questions.]

4. Does the patient meet ONE of the following? Please indicate which of the below apply to patient (if patient has contraindication to Enbrel or Humira, list contraindication): Y N

_____

Trial and failure of at least 3 months of a compliant regimen of Enbrel or Humira OR \ Documented intolerance or contraindication to Enbrel or Humira

[If yes, skip to question 9.]

[If no, no further questions.]

5. Does the patient have a diagnosis of juvenile idiopathic arthritis? Y N

[If no, no further questions.]

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

[If no, no further questions.]

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

[If no, no further questions.]

8. Does the patient meet BOTH of the following? Please indicate which of the below apply to patient (if patient has contraindication to Enbrel or Humira, list contraindication): Y N

_____

Trial and failure of a compliant regimen of methotrexate for at least 3 months AND \ Trial and failure of at least 3 months of a compliant regimen of Enbrel or Humira or documented intolerance or contraindication to Enbrel or Humira.

[If no, no further questions.]

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

[If no, no further questions.]

10. Will Orencia be given in combination with a TNF-alpha antagonist (e.g., Enbrel, Humira, or Remicade)? 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