PRIOR AUTHORIZATION REQUEST
Orencia

PATIENT: Name______________________
Address: ______________________
City, State, Zip_____________________
D.O.B. _____________________
Member ID:________________________

Prescriber: Name______________________
Address ______________________
City, State, Zip_____________________
Phone _____________________
Fax _____________________
NPI _____________________

Medication Requested:___________ Qty Requested: ___________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic disease-modifying antirheumatic drug (DMARD) used for an inflammatory condition?
   - ☐ Biologic DMARD
   - ☐ Targeted synthetic DMARD
   - ☐ Conventional synthetic DMARD – **Please proceed to question 2**
   - ☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease-modifying anti-rheumatic drug (DMARD) – **Please proceed to question 2**
2. ☐ Yes ☐ No Is the patient currently receiving Orencia (IV or SC)?
3. What is the patient's diagnosis?
   - ☐ Rheumatoid arthritis (RA) – **Please answer questions 4 & 6 - 8**
   - ☐ Juvenile Idiopathic Arthritis (JIA) [or Juvenile Rheumatoid Arthritis {JRA}] (regardless of type of onset) – **Please answer questions 8 - 13**
   - ☐ Psoriatic arthritis (PsA) – **Please answer questions 5 & 14**
   - ☐ Inflammatory bowel disease (for example, Crohn's disease, ulcerative colitis)
   - ☐ Psoriasis
   - ☐ Ankylosing spondylitis (AS)
   - ☐ All other indications or diagnoses – Please Specify ______________________________________
4. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
5. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
6. ☐ Yes ☐ No Has the patient tried one conventional synthetic disease-modifying antirheumatic drug (DMARD) (brand or generic; oral or injectable) for at least 3 months?
7. ☐ Yes ☐ No Has the patient tried one biologic disease-modifying antirheumatic drug (DMARD) for at least 3 months?
8. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a rheumatologist?

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9. ☐ Yes ☐ No Has the patient tried one other agent for this condition?
10. ☐ Yes ☐ No Will the patient be starting on Orencia SC concurrently with methotrexate (MTX), sulfasalazine, or leflunomide?

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851