maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Orencia Subq

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the patient be using Orencia SC in combination with other biologics or targeted disease modifying antirheumatic drugs (DMARDS) such as: Biologic DMARDs - adalimumab SC products (Humira, biosimilars), Cimzia, etanercept SC products (Enbrel, biosimilars), infliximab IV products (Remicade, biosimilars), Actemra (IV or SC), Simponi SC, Simponi Aria (IV), Kevzara, Orencia (IV), rituximab IV products (Rituxan, biosimilars), Ilaris, Kineret, Stelara (SC or IV), Siliq, Cosentyx, Taltz, Ilumya, Skyrizi, Tremfya, Entyvio OR Targeted synthetic DMARD (such as Otezla, Olumiant, Rinvoq, or Xeljanz/XR)? [If yes, no further questions.]	Yes	No
2	Is the patient currently receiving Orencia SC? [If no, skip to question 11.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication?	Yes	No

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	[If yes, skip to question 11.]		
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 11.]	Yes	No
6	What is the patient's diagnosis? [] Rheumatoid arthritis (RA) (If checked, go to 7) []Juvenile idiopathic arthritis (JIA) [or juvenile rheumatoid arthritis {JRA}] (regardless of type of onset) (If checked, go to 7) [] Psoriatic arthritis (PsA) (this includes patients with concomitant plaque psoriasis and psoriatic arthritis) (If checked, go to 7) [] Inflammatory bowel disease (for example, Crohn's disease, ulcerative colitis) (If checked, no further questions) [] Psoriasis (If checked, no further questions) [] Ankylosing spondylitis (AS) (If checked, no further questions) [] All other indications (If checked, no further questions)		
7	Has the patient experienced a beneficial clinical response when assessed by AT LEAST ONE objective measure? [Note: Examples of standardized and validated measures of disease activity include Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS) 28 using erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), Patient Activity Scale (PAS)-II, Rapid Assessment of Patient Index Data 3 (RAPID-3), and/or Simplified Disease Activity Index (SDAI).] [If yes, no further questions.]	Yes	No
8	Has the patient experienced an improvement in AT LEAST ONE symptom, such as decreased joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths? [No further questions.]	Yes	No
9	Has the patient experienced a beneficial clinical response when assessed by AT LEAST ONE objective measure? [Note: Examples of standardized and validated measures of disease activity include Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS) 28 using erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), Patient Activity Scale (PAS)-II, Rapid Assessment of Patient Index Data 3 (RAPID-3), and/or Simplified Disease Activity Index (SDAI).] [If yes, skip to question 11.]	Yes	No

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10	Has the patient experienced an improvement in AT LEAST ONE symptom, such as decreased joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths? [If no, no further questions.]	Yes	No
11	What is the indication or diagnosis? [] Rheumatoid arthritis (RA) (If checked, go to 12) []Juvenile idiopathic arthritis (JIA) [or juvenile rheumatoid arthritis {JRA}] (regardless of type of onset) (If checked, go to 19) [] Psoriatic arthritis (PsA) (this includes patients with concomitant plaque psoriasis and psoriatic arthritis) (If checked, go to 13) [] Inflammatory bowel disease (for example, Crohn's disease, ulcerative colitis) (If checked, no further questions) [] Psoriasis (If checked, no further questions) [] Ankylosing spondylitis (AS) (If checked, no further questions) [] All other indications (If checked, no further questions)		
12	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If yes, skip to question 14.] [If no, no further questions.]	Yes	No
13	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
14	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
15	Has the patient tried AT LEAST TWO conventional synthetic disease-modifying antirheumatic drug (DMARD) for AT LEAST 3 months? [Note: Examples of conventional synthetic DMARDs are methotrexate (oral or injectable), leflunomide, sulfasalazine, and hydroxychloroquine.] [If yes, skip to question 17.]	Yes	No
16	Has documentation been provided to confirm that the patient has an intolerance to AT LEAST TWO conventional synthetic agents? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with preferred Tumor Necrosis Factor (TNF) inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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18	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 25.] [If no, no further questions.]	Yes	No
19	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
20	Has the patient tried AT LEAST TWO systemic agents for this condition for AT LEAST 3 months? [Note: Examples of therapies which could have been tried include methotrexate, sulfasalazine, or leflunomide, and a nonsteroidal anti-inflammatory drug (NSAID).] [If yes, skip to question 22.]	Yes	No
21	Has documentation been provided to confirm that the patient has an intolerance to AT LEAST TWO other agents? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	Does the patient have aggressive disease, according to the prescriber? [If no, no further questions.]	Yes	No
23	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with preferred Tumor Necrosis Factor (TNF) inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication?	Yes	No

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

SECTION B: Physician Signature

If you have any questions, call: 1-888-258-8250

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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