PRIOR AUTHORIZATION REQUEST

Orencia SQ

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the requested medication be used in combination with other biologics or targeted disease modifying antirheumatic drugs (DMARDs)? [Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Cimzia, etanercept SC products (for example, Enbrel, biosimilars), infliximab IV products (for example, Remicade, biosimilars), Actemra (IV or SC), Simponi SC, Simponi Aria (IV), Kevzara, Orencia (IV), rituximab IV products (for example, Rituxan, biosimilars), Ilaris, Kineret, Stelara (SC or IV), Siliq, Cosentyx, Taltz, Ilumya, Skyrizi, Tremfya, Entyvio. Examples of targeted synthetic disease-modifying antirheumatic drugs (DMARDs) include but not limited to Otezla, Olumiant, Rinvoq, Xeljanz/XR.]	Yes	No

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	[If yes, no further questions.]		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
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 7.]	Yes	No
5	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been provided to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Rheumatoid arthritis (RA) (If checked, go to 8) [] Polyarticular juvenile idiopathic arthritis (JIA) (or juvenile rheumatoid arthritis [JRA]) (regardless of type of onset) (If checked, go to 14) [] Psoriatic arthritis (PsA) (this includes patients with concomitant plaque psoriasis and psoriatic arthritis) (If checked, go to 20) [] 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) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
9	Has the patient tried AT LEAST TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for AT LEAST 3 months? [Note: Examples of conventional synthetic DMARDs are methotrexate (oral or injectable), leflunomide, sulfasalazine, hydroxychloroquine.]	Yes	No

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	[If yes, skip to question 11.]		
10	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
11	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 (Simlandi, Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	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
13	Is the requested medication being prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No
14	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
15	Has the patient tried ONE other agent for AT LEAST 3 months for the patient's condition? [Note: Examples of other agents for JIA include but not limited to methotrexate (MTX), sulfasalazine, leflunomide.] [If yes, skip to question 17.]	Yes	No
16	Does the patient have an absolute contraindication to methotrexate (MTX), sulfasalazine, or leflunomide? [Note: Examples of contraindications to MTX include pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias.] [If no, no further questions.]	Yes	No
17	Has documentation been provided to confirm that the patient had 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 (Simlandi, Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with an IL-6 inhibitor (Actemra)? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[If no, no further questions.]		
19	Is the requested medication being prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No
20	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
21	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
22	Has the patient tried AT LEAST TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for AT LEAST 3 months? [Note: Examples of conventional synthetic DMARDs are methotrexate (oral or injectable), leflunomide, sulfasalazine, hydroxychloroquine.] [If yes, skip to question 24.]	Yes	No
23	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
24	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 (Simlandi, Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Has documentation been provided to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for AT LEAST 3 months OR has documentation been provided to confirm that the patient had an intolerance or has a contraindication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
26	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.	Yes	No

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

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SECTION B: Physician Signature

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