PRIOR AUTHORIZATION REQUEST

ORENCIA

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	Is the request for INITIAL therapy or for a CONTINUATION of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	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	Yes	No

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

Version 06.2026

PRIOR AUTHORIZATION REQUEST

	(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.] [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
5	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 8.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has experienced a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	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.] [If yes, no further questions.]	Yes	No
9	What is the indication or diagnosis? [] Rheumatoid arthritis (RA) (If checked, go to 10) [] Polyarticular juvenile idiopathic arthritis (JIA) (or juvenile rheumatoid arthritis [JRA]) (regardless of type of onset) (If checked, go to 16)		

PRIOR AUTHORIZATION REQUEST

[] Psoriatic arthritis (PsA) (this includes patients with concomitant plaque psoriasis and psoriatic arthritis) (If checked, go to 22)

[] Other (If checked, no further questions)

10	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
11	Has documentation been submitted to confirm that the patient has experienced a treatment failure with AT LEAST 2 systemic agents for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of systemic agents include methotrexate (oral or injectable), leflunomide, sulfasalazine, hydroxychloroquine.] [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has experienced a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has documentation been submitted to confirm that the patient has experienced a treatment failure with Xeljanz (tofacitinib) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
15	Does the requested dose exceed FDA approved label dosing for the requested indication? Note: Dosing is 125 mg subq once per week. [No further questions.]	Yes	No
16	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
17	Has documentation been submitted to confirm that the patient has experienced a treatment failure with AT LEAST ONE other agent for AT LEAST 3 months unless intolerant or contraindicated? [Note: Examples of other agents for JIA include but not limited to methotrexate (MTX), sulfasalazine, leflunomide.] [If no, no further questions.]	Yes	No
18	Has documentation been submitted to confirm that the patient has experienced a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or	Yes	No

PRIOR AUTHORIZATION REQUEST

	adalimumab-adbm) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
19	Has documentation been submitted to confirm that the patient has experienced a treatment failure for AT LEAST 3 months with an IL-6 inhibitor, Actemra, unless intolerant or contraindicated. ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
21	Does the requested dose exceed FDA approved label dosing for the requested indication? Note: Dosing is patients 10kg to less than 25kg: 50mg subq once per week, 25kg to less than 50kg: 87.5mg subq once per week, greater than or equal to 50kg: 125 mg subq once per week. [No further questions.]	Yes	No
22	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
23	Has documentation been submitted to confirm that the patient has experienced a treatment failure with AT LEAST 2 systemic agents for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs are methotrexate (oral or injectable), leflunomide, sulfasalazine, hydroxychloroquine.] [If no, no further questions.]	Yes	No
24	Has documentation been submitted to confirm that the patient has experienced a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Has documentation been submitted to confirm that the patient has experienced 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 experienced an intolerance or has a contraindication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
26	Has documentation been submitted to confirm that the patient has experienced a treatment failure with Xeljanz (tofacitinib) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
27	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
28	Does the requested dose exceed FDA approved label dosing for the requested indication? Note: Dosing is patients 10kg to less than 25kg: 50mg subq once per week, 25kg to less than 50kg: 87.5mg subq once per week, greater than or equal to 50kg: 125 mg subq once per week.	Yes	No

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

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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