Orencia (Abatacept)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

Revision Date: 6/15/24

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Juvenile idiopathic arthritis ☐ Psoriatic arthritis (PsA) ☐ Rheumatoid arthritis (RA) ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is Orencia being prescribed by a rheumatologist or dermatologist? ☐ Yes ☐ No

Is the patient on concurrent treatment with another biologic response modifier or immunomodulatory agent (e.g., Rituxan, Remicade, Humira, Enbrel, Simponi, Cimzia, Actemra, etc.)? ☐ Yes ☐ No

Has the patient had a trial and inadequate response with methotrexate or another oral non-biologic disease modifying anti-rheumatic agent (DMARD) such as Imuran, Ridaura, Plaquenil, sulfasalazine, cyclosporine or Arava? ☐ Yes ☐ No ***Please provide documentation and dates of service*.**

Is the patient unable to take the prerequisite non-biologic DMARD due to chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)?* ☐ Yes ☐ No

If 'no' to the above, please provide rationale (if applicable) explaining why the patient is unable to take the required disease modifying anti-rheumatic agent (DMARD) prerequisite: _____

_____

Has the patient tried and failed at least a three-month trial of the biosimilar for Humira-adalimumab-aacf? ☐ Yes ☐ No ***Please provide documentation and dates of service.***

Does the patient have concomitant heart failure? ☐ Yes ☐ No

<u>Reauthorization:</u>

If this is a reauthorization request, answer the following questions:

Is Orencia being prescribed by a rheumatologist or dermatologist? ☐ Yes ☐ No

Is the patient on concurrent treatment with another biologic response modifier or immunomodulatory agent (e.g., Rituxan, Remicade, Humira, Enbrel, Simponi, Cimzia, Actemra, etc.)? ☐ Yes ☐ No

Has the patient had a positive clinical response and is remission of disease being maintained with continued use of Orencia?*☐ Yes ☐ No

Please provide supporting chart notes.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811