

**Orencia® (abatacept)**

**PreDetermination of Medical Benefits**

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

<b>Click on grey boxes to type</b>	<b>Request Date:</b>	/	/	/
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<input type="checkbox"/> <b>Initial Authorization Request</b>	<input type="checkbox"/> <b>Re-Authorization Request; List Prior Auth Ref #:</b>
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<input type="checkbox"/> <b>Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions FAX (800-824-2642)</b>
<b>Ship Medication to:</b> <input type="checkbox"/> MD Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other: (please specify)

**1. PATIENT INFORMATION – ALL INFORMATION REQUIRED**

<b>Patient Last Name</b>	<b>Patient First Name</b>	<b>Anthem Member ID Number</b>	<b>Patient DOB</b> / /
<b>Contact Phone Number</b> ( ) -	<b>Primary Diagnosis</b>	<b>ICD-9 Code(s)</b>	<b>Patient's Weight (lbs/kg)</b> Date: _____

**2. PHYSICIAN INFORMATION – ALL INFORMATION REQUIRED**

<b>Physician Last Name</b>	<b>Physician First Name</b>	<b>Physician DEA or NPI Number</b>	<b>Physician Tax ID</b>
<b>Address</b>		<b>City</b>	<b>State</b>
<b>Zip Code</b>			
<b>Office Phone Number</b> ( ) -	<b>Office Fax Number</b> ( ) -	<b>Office Contact Name</b>	<b>Physician Specialty</b>

**3. MEDICATION INFORMATION – ALL INFORMATION REQUIRED**

<b>HCPCS Code/Drug Name</b> J0129-Orencia	<b>Dose to be administered (mg)</b>	<b>When did the member first start this drug?</b>
<b>Frequency (weeks)</b>	<b>Duration (weeks)</b>	<b>Start Date For This Request</b>

**Place of Service:**  Home  Office  Dialysis Center  Outpatient Hospital  Ambulatory Infusion  Ambulatory Infusion Center  
 Other: \_\_\_\_\_

**4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**(1) Rheumatoid Arthritis (RA)**

Yes  No Is patient 18 years or older?

Yes  No Is patient diagnosed with moderately to severely active rheumatoid arthritis?

Yes  No Did patient have an inadequate response or unresponsive to one or more DMARDs (Disease-Modifying AntiRheumatic Drugs) or TNF (Tumor Necrosis Factor) antagonists?

**Please check drugs tried:**

<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Remicade	<input type="checkbox"/> Cimzia
<input type="checkbox"/> Sulfasalazine (Azulfidine)	<input type="checkbox"/> Enbrel	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hydroxychloroquine (Plaquenil)	<input type="checkbox"/> Humira	

Yes  No Is the patient on concomitant therapy with other immune modulators, e.g. Remicade, Enbrel, Humira, Kineret?

**(2) Juvenile Idiopathic Arthritis**

Yes  No Is the patient at least 6 years old?

Yes  No Is patient diagnosed with moderate to severely active polyarticular Juvenile Idiopathic Arthritis (JIA)?

Yes  No Is this to be used as monotherapy?

Yes  No Is this to be used in combination with methotrexate?

Yes  No Is the patient receiving TNF antagonists (such as Remicade, Enbrel, Humira or Cimzia)?

**(3) Other Use(s)** (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

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**5. PHYSICIAN SIGNATURE**

<b>Prescriber's or Authorized Representative's Signature:</b>  _____	<b>Date:</b> ____ / ____ / ____
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Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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**Medical Policy Reference can be found at:** [www.bcbsga.com](http://www.bcbsga.com)  
Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.