FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Orencia® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Adult rheumatoid arthritis
❑ Juvenile idiopathic arthritis
❑ Psoriatic arthritis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the requested medication recommended by a rheumatologist? ❑ **Yes** ❑ **No**

Will the patient receive Orencia concurrently with biological disease-modifying anti-rheumatic drugs (DMARDs) or other tumor necrosis factor antagonists? ❑ **Yes** ❑ **No**

Is there documentation the patient has been evaluated for active or latent tuberculosis (TB)? ❑ **Yes** ❑ **No**

For new starts only: Have at least 2 weeks passed since the administration of the Herpes Zoster vaccine prior to start of therapy? ❑ **Yes** ❑ **No**

For intravenous (IV) administration:

Will Orencia IV be given in the home setting or long term care facility? ❑ **Yes** ❑ **No**

Is there documentation the patient has had an inadequate response to at least ONE disease-modifying anti-rheumatic drug (DMARD) such as methotrexate? ❑ **Yes** ❑ **No**

For subcutaneous (SC) administration:

Is there documentation the patient has had an inadequate response or inability to tolerate both Humira (adalimumab and Enbrel (etanercept)? ❑ **Yes** ❑ **No**

If "no" to the above question, is there documentation demonstrating that a trial with both Humira (adalimumab and Enbrel (etanercept) may be inappropriate for the patient? ❑ **Yes** ❑ **No**

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: This request may be denied unless all required information is received.