



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

### Orencia® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:	Dosage Form:	
<input type="checkbox"/> Check if generic substitution is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Active psoriatic arthritis					
<input type="checkbox"/> Moderately to severely active polyarticular juvenile idiopathic arthritis					
<input type="checkbox"/> Moderately to severely active rheumatoid arthritis					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical Information:</b>					
Select if Orencia is prescribed by or in consultation with one of the following specialists:					
<input type="checkbox"/> Dermatologist					
<input type="checkbox"/> Rheumatologist					
Is this request for continuation of prior Orencia therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For active psoriatic arthritis, also answer the following:</b>					
Select if the patient has had a trial and failure, contraindication or intolerance to the following:					
<input type="checkbox"/> Cimzia (certolizumab)		<input type="checkbox"/> Simponi (golimumab) or Simponi Aria (golimumab IV)			
<input type="checkbox"/> Cosentyx (secukinumab)		<input type="checkbox"/> Stelara (ustekinumab)			
<input type="checkbox"/> Humira (adalimumab)		<input type="checkbox"/> Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)			
<b>For moderately to severely active polyarticular juvenile idiopathic arthritis, also answer the following:</b>					
Has the patient had trial and failure, contraindication, or intolerance to one of the following non-biologic disease modifying anti-rheumatic drugs (DMARDs): Rheumatrex/Trexall (methotrexate) or Arava (leflunomide)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient had a trial and failure, contraindication, or intolerance to Humira (adalimumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For moderately to severely active rheumatoid arthritis (RA), also answer the following:</b>					
Has the patient had trial and failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Rheumatrex/Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine)]? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has had trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be inappropriate:					
<input type="checkbox"/> Actemra (tocilizumab)		<input type="checkbox"/> Simponi (golimumab) or Simponi Aria (golimumab IV)			
<input type="checkbox"/> Cimzia (certolizumab)		<input type="checkbox"/> Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)			
<input type="checkbox"/> Humira (adalimumab)					
<b>Reauthorization:</b>					
<b>If this is a reauthorization request, answer the following:</b>					
Is there documentation the patient has a positive clinical response to Orencia therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.

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

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