aetna™

MEDICARE FORM

Orencia® (abatacept) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857

For other lines of business:
Please use other form.

Note: Orencia is non preferred. Renflexis is preferred for MA products and Humira is preferred for MAPD plans.

Please indicate: ☐ Start of treatment, **Start Date:** ____/____/____ ☐ Continuation of therapy, date of last treatment: ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs	Patient Height: _____ inches or _____ cms	Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Please explain if there are any medical reason(s) why the patient cannot self-inject the requested drug:

_____

_____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Orencia (abatacept):
Dose: _____ **Frequency:** _____
HCPCS Code: _____ ☐ IV ☐ SC

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For Initiation requests (clinical documentation required):

☐ Yes ☐ No Will Orencia (abatacept) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?

→ (Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ Positive ☐ Negative ☐ Unknown
If positive, Does the patient have latent or active TB? ☐ Latent ☐ Active
If latent TB, ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with Orencia (abatacept)?

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☐ Yes ☐ No Has the patient had prior therapy with Orencia (abatacept) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Renflexis (infliximab-abda)?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Humira (adalimumab)?

Please explain if there are any other medical reason(s) that the patient cannot use Renflexis (infliximab-abda).

_____

_____

Please explain if there are any other medical reason(s) that the patient cannot use Humira (adalimumab).

_____

_____

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G. CLINICAL INFORMATION (*continued*) – Required clinical information must be completed in its entirety for all precertification requests.

Juvenile idiopathic arthritis (juvenile rheumatoid arthritis)

Please indicate the severity of the patient's disease: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Has the patient had an ineffective response to Enbrel (etanercept)?

→ ☐ Yes ☐ No Was treatment with Enbrel (etanercept) not tolerated or contraindicated?

Please select: ☐ not tolerated ☐ contraindicated

→ Please indicate the length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

For IV formulation only:

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Is the patient medically unstable for infusions at alternate levels of care?

☐ Yes ☐ No Does the patient have a history of any cardiopulmonary conditions?

→ Please provide the description of the condition: _____

☐ Yes ☐ No Does this condition cause an increased risk of severe adverse reactions?

☐ Yes ☐ No Does the patient have documentation of unstable vascular access?

☐ Yes ☐ No Does the patient have physical or cognitive impairments such that home infusion would present an unnecessary health risk?

→ Please explain: _____

☐ Yes ☐ No Is there clinical evidence that the patient has an inability to safely tolerate intravenous volume load (including from unstable renal function)?

→ ☐ Yes ☐ No Is the inability to tolerate intravenous volume load due to unstable renal function?

→ Please document the following: ☐ GFR:_____ mL/min/1.73m^2 Date Collected: ____/____/____

☐ BUN:_____ mg/dL Date Collected: ____/____/____

☐ Creatinine:_____ mg/dL Date Collected: ____/____/____

Psoriatic Arthritis

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?

→ ☐ Yes ☐ No Was the treatment with 2 or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?

→ Please provide the names and length of treatment:

NSAID #1: _____

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

NSAID #2: _____

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?

→ ☐ Yes ☐ No Was treatment with methotrexate ineffective?

→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?

→ Please select: ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was a trial with a conventional disease-modifying anti-rheumatic drug ineffective?

→ Please select: ☐ cyclophosphamide ☐ cyclosporine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine ☐ Other: Please explain: _____

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

→ Please indicate the length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Rheumatoid Arthritis

Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Was treatment with methotrexate ineffective?

→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?

→ Please select: ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with another conventional DMARD (other than methotrexate) ineffective?

→ Provide select: ☐ azathioprine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine

Please indicate the length of the DMARD treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

→ Please indicate the length of the methotrexate therapy: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION (*continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Continuation requests (clinical documentation required):

☐ Yes ☐ No Will Orencia (abatacept) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

Please indicate the severity of the patient's disease at baseline (pretreatment with Orencia (abatacept)): ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Does the patient have any risk factors for TB?

→ ☐ Yes ☐ No Has the patient had a TB test within the past year?
(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please the results of the TB test: ☐ Positive ☐ Negative ☐ Unknown

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Orencia (abatacept)?

For Juvenile idiopathic arthritis (juvenile rheumatoid arthritis) IV formulation only (continuation of therapy requests only):

☐ Yes ☐ No Has the patient received Orencia (abatacept) within the past 6 months?

→ ☐ Yes ☐ No Does the patient have a documented severe and/or potentially life threatening adverse event that occurred during or following the previous infusion?

→ ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the home or office setting?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests