

Neighborhood Health Plan of Rhode Island Prior Authorization Form Orencia® (abatacept)

Date of Request: _____

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Orencia® (abatacept). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

| | | | | | | | | | | | |
|---|---|--|--|--|--|--|--|--|--|--|--|
| Member Name: (required) | Member ID Number: (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> | | | | | | | | | | |
| | | | | | | | | | | | |
| Member Date of Birth: (required) / / | Member Sex: M F (Circle One) | | | | | | | | | | |
| Prescriber Name: (required) | Contact Person at Office: | | | | | | | | | | |
| Office Phone number: (required) () - | Office Fax Number: (required) () - | | | | | | | | | | |

ASSESSMENT OF BENEFIT NEED:

| INDICATIONS FOR USE | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 1) FOR REDUCTION IN SIGNS AND SYMPTOMS AND INHIBITION OF THE PROGRESSION OF STRUCTURAL DAMAGE IN PATIENTS WITH MODERATELY TO SEVERELY ACTIVE RHEUMATOID ARTHRITIS (RA). | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) PATIENT HAS HAD AN UNSATISFACTORY RESPONSE TO A PREVIOUS TRIAL OF A DISEASE MODIFYING ANTIRHEUMATIC DRUG (DMARD) AND PREVIOUS TNF THERAPY (E.G., HYDROXYCHLOROQUINE (PLAQUENIL®), AZATHIOPRINE (IMURAN®), SULFASALAZINE (AZULFIDINE®), CYCLOPHOSPHAMIDE (CYTOXAN®), CYCLOSPORINE (NEORAL®), METHOTREXATE), ANAKINRA (KINERET®), ETC PLEASE LIST PRIOR THERAPIES: a) _____ b) _____ c) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) FOR REDUCTION OF SIGNS AND SYMPTOMS OF MODERATELY TO SEVERE ACTIVE POLYARTICULAR-COURSE JUVENILE RA | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) IF THE PATIENT HAS NOT RECEIVED PREVIOUS TNF THERAPY, PLEASE INDICATE REASON IN THE SPACE BELOW. _____ | | |
| 5) IF THIS IS FOR RENEWAL, HAS THE PATIENT SHOWN SYMPTOMATIC IMPROVEMENT? PLEASE DESCRIBE: _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <ul style="list-style-type: none"> ▪ Patients should be evaluated for latent tuberculosis with a tuberculin skin test prior to abatacept therapy. Treatment of latent TB should be initiated before abatacept is used. ▪ Rare reactivation of hepatitis B has occurred in chronic virus carriers. ▪ Use caution in patients with pre-existing or recent-onset demyelinating CNS disorders. | | |

BENEFIT TERMS UPON APPROVAL:

INITIAL APPROVAL WILL BE FOR 3 MONTHS AT WHICH TIME PATIENT SHOULD BE EVALUATED FOR RESPONSE TO THERAPY. IF PATIENT IS RESPONDING TO THERAPY, AN ADDITIONAL 9 MONTHS WILL BE APPROVED.

All information provided on this form is accurate as of this date.

Provider Signature: _____ **NPI:** _____ **Date:** _____

Is the doctor's office supplying the medication? _____

**Completed forms should be faxed to:
Neighborhood Customer Service Department – 866-423-0945**