

**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:

<b>Member Name:</b> (required)	<b>Member ID Number:</b> (required)
<b>Member Date of Birth:</b> (required) / /	<b>Member Sex:</b> M F (Circle One)
<b>Prescriber Name:</b> (required)	<b>Contact Person at Office:</b>
<b>Office Phone number:</b> (required) ( ) -	<b>Office Fax Number:</b> (required) ( ) -

**ASSESSMENT OF BENEFIT NEED:**

INDICATIONS FOR USE	YES	NO
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) <b>AND</b> 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) IF THE PATIENT HAS NOT RECEIVED PREVIOUS TNF THERAPY, PLEASE INDICATE REASON IN THE SPACE BELOW.  _____		
4) IF THIS IS FOR RENEWAL, HAS THE PATIENT SHOWN SYMPTOMATIC IMPROVEMENT? PLEASE DESCRIBE:  _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
5) IS THE PATIENT HYPERSENSITIVE TO ORENCIA OR ANY OF ITS COMPONENTS?	<input type="checkbox"/>	<input type="checkbox"/>

**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:  
Customer Service Department  
NHPRI  
866-423-0945**