Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Orencia

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579**. If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: ____________________ **Date**: ____________________
Patient's ID: ____________________ **Patient's Date of Birth:** ____________________
Physician's Name: ____________________
Specialty: ____________________ **NPI#:** ____________________
Physician Office Telephone: ____________________ **Physician Office Fax:** ____________________
Physician Office Address: ____________________

1. Which drug is being prescribed? ❑ Orencia Dose:_________ Frequency:________ ❑ Other _______
2. What is the diagnosis?
   ❑ Rheumatoid Arthritis (RA) ❑ Polyarticular Juvenile Idiopathic Arthiritis (JIA) ❑ Other _______
3. What is the patient's age? _________________ **years**
4. What is the medical specialty of the prescribing physician? ❑ Rheumatologist ❑ Other ___________
5. Does the patient have negative tuberculosis (TB) test? **If yes, skip to # 8* ❑ Yes ❑ No
6. Has active TB been ruled out via negative chest x-ray? ❑ Yes ❑ No
7. Was chest x-ray taken within last 12 months? ❑ Yes ❑ No
8. Does the patient have signs or symptoms of active infection, either chronic or localized? ❑ Yes ❑ No
9. Does the patient have a history of hepatitis B infection? ❑ Yes ❑ No
10. Has the patient been treated for hepatitis B infection? ❑ Yes ❑ No
11. Does the patient have a history of malignant disease? ❑ Yes ❑ No
12. Has the patient been informed to avoid receiving a live vaccine within 3 months after any doses of Orencia? ❑ Yes ❑ No
13. Will Orencia be used in combination with any other biologic medication(s)? ❑ Yes ❑ No
14. Is the patient currently receiving Orencia therapy? ❑ Yes ❑ No **If no, skip to # 18*
15. Is the patient compliant with Orencia therapy? ❑ Yes ❑ No
16. Did the patient demonstrate a therapeutic response? ❑ Yes ❑ No
17. Did the patient develop malignancy? ❑ Yes ❑ No

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Patient Name: ______________________________ **Patients Date of Birth:** ________________________
Patients ID : ______________________________

18. Has the patient had a trial of biologic therapy other than Orencia for 3 consecutive months?
❑ Yes (indicate biologic below) ❑ No **If no, skip to # 21*
❑ Cimzia ❑ Enbrel ❑ Humira ❑ Kineret ❑ Remicade ❑ Rituxan ❑ Simponi
19. Has the patient had an inadequate response to previous biologic therapy? ❑ Yes ❑ No
20. Was the patient adherent to prescribed biologic therapy? ❑ Yes, **submit documentation** ❑ No
21. Was the patient intolerant to previous biologic therapy? ❑ Yes, **submit documentation** ❑ No

Complete Section below designated for the patient's diagnosis

Section A: Diagnosis Rheumatoid Arthritis AND Polyarticular Juvenile Idiopathic Arthiritis

22. Has the patient had a trial of either methotrexate or leflunomide for at least 3 consecutive months?
❑ Yes ❑ No **If no, skip to # 24*
23. Has the patient had an inadequate response to either methotrexate or leflunomide?
**If yes, skip to # 28* ❑ Yes ❑ No
24. Is the patient intolerant or contraindicated to either methotrexate or leflunomide? ❑ Yes ❑ No
25. Has the patient had a trial of another nonbiologic DMARD for at least 3 consecutive months (e.g., hydroxychloroquine, cyclosporine, sulfasalazine, gold, azathioprine)? ❑ Yes ❑ No
26. Has the patient had an inadequate response to such therapy? ❑ Yes ❑ No
27. Is the patient intolerant or contraindicated to such therapy? ❑ Yes ❑ No
28. Was the patient adherent to prescribed therapy? ❑ Yes ❑ No
29. S**ubmit documentation of last trial of non-biologic DMARD.**

****If patient has a diagnosis of Rheumatoid Arthritis, complete the last two questions in addition to the section above****

30. Prior to therapy, did the patient have 6 or more inflamed joints? ❑ Yes ❑ No
31. Prior to therapy, did the patient have at least one of the following characteristics? ❑ Yes ❑ No
❑ Elevation of erythrocyte sedimentation rate and/or serum c-reactive protein concentration
❑ Positive rheumatoid factor and/or anti-cyclic citrullinated peptide
❑ Radiography showing evidence of rheumatoid arthritis, including osteopenia and/or joint space narrowing and/or bony erosions and/or loss of cartilage

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

Information given on this form is accurate as of this date:

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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