

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ORENCIA(abatacept)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and opt: _____ Fax# _____

Physician's NPI: _____

Patient's current wt. _____ Am't per dose _____ # of tx in 6 mos _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTE OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

- ▶ Patient is 18 years old or older
- ▶ Covered for moderate to severe rheumatoid arthritis
- ▶ Must have inadequate response to one or more DMARD's such as MTX ***OR***
have inadequate response to one or more TNF such as anakinra, entercept or infliximab
- ▶ Patient is not on TNF medication
- ▶ 6 or more swollen joints (**WRITE SPECIFIC NUMBER IN NOTES OR LETTER**)
- ▶ 9 or more tender joints (**WRITE SPECIFIC NUMBER IN NOTES OR LETTER**)
- ▶ Patient is absent of active bacterial or viral infection, malignancy, or immunosuppressive condition
- ▶ There has been a rheumatology consult within the last 60 days

INFORMATION:

To be administered in clinic setting only. Patient's with HMO's (except IHC) will have to make arrangements with their HMO coverage. Provider will bill with J code J0129 and a PA number.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

An updated letter or progress note needs to be sent in showing improvement or maintenance as the result of using Orencia.