aetna®

MEDICARE FORM

Orencia® (abatacept) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
Phone: 1-866-503-0857 (TTY: 711)
FAX: 1-844-268-7263

For other lines of business:
Please use other form.

Note: Orencia is non-preferred. Preferred products vary based on indication. See section G below.

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:
Provider Email:	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: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

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: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

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)?

Note: Orencia is non-preferred. Inflectra, Remicade, Simponi Aria, and unbranded infliximab are preferred for MA plans. Enbrel, Humira, Kevzara, Otezla, Rinvoq, Skyrizi, Stelara, Tremfya and Xeljanz/Xeljanz XR are preferred for MAPD plans. Preferred products vary based on indication.

☐ Yes ☐ No Has the patient had prior therapy with Orencia (abatacept) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Simponi Aria (golimumab) ☐ Unbranded infliximab
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Kevzara (sarilumab) ☐ Otezla (apremilast) ☐ Rinvoq (upadacitinib)
☐ Skyrizi (risankizumab-rzaa) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab) ☐ Xeljanz/Xeljanz XR (tofacitinib)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply).
☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Simponi Aria (golimumab) ☐ Unbranded infliximab

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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.

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)

☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Kevzara (sarilumab) ☐ Otezla (apremilast) ☐ Rinvoq (upadacitinib)
☐ Skyrizi (risankizumab-rzaa) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab) ☐ Xeljanz/Xeljanz XR (tofacitinib)

_____

_____

Chronic graft versus host disease

☐ Yes ☐ No Has the patient experienced an inadequate response to systemic corticosteroids?
→ ☐ Yes ☐ No Does the patient have an intolerance or contraindication to corticosteroids?

Giant cell arteritis

☐ Yes ☐ No Has the patient been diagnosed with giant cell arteritis?

Immune checkpoint inhibitor-related toxicity

☐ Yes ☐ No Does the patient have myocarditis?
→ ☐ Yes ☐ No Has the patient responded to systemic corticosteroids?

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?

Prophylaxis of acute graft versus host disease

☐ Yes ☐ No Is the patient undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated-donor?
→ ☐ Yes ☐ No Will the requested medication be used in combination with a calcineurin inhibitor (e.g., cyclosporine, tacrolimus) and methotrexate?

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 of treatment:
NSAID #1: _____
NSAID #2: _____

☐ 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: _____

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

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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.