# Orencia® (abatacept) Injectable Medication Precertification Request



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

**Aetna Precertification Notification**
**Phone:** 1-866-752-7021
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**
Please Use Medicare Request Form

**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:

**Medicare:** ☐ Yes ☐ No If yes, provide ID #:

**Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

## 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: | |

**Specialty** *(Check one):* ☐ **Oncologist** ☐ **Rheumatologist** ☐ **Other**: _____

## 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: _____

**Dispensing Provider/Pharmacy:** *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ FAX: _____
**TIN:** _____ PIN: _____

## E. PRODUCT INFORMATION

**Request is for: Orencia (abatacept) Dose:** _____ **Frequency:** _____

## 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 All Requests (clinical documentation required for all requests):**

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition: ☐ Cardiopulmonary: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

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**G. CLINICAL INFORMATION (*continued*)** – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?

→ ☐ Yes ☐ No Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

→ (Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

Please enter the results of the tuberculosis (TB) test: ☐ positive ☐ negative ☐ unknown

***If positive,*** please indicate which applies to the patient:

☐ latent TB and treatment for latent TB has been initiated

☐ latent TB and treatment for latent TB has been completed

☐ latent TB and treatment for latent TB has not been initiated

☐ active TB

**For Initiation Requests (clinical documentation required for all requests):**

**Chronic graft versus host disease**

Please indicate loading dose at weeks 0, 2 and 4:_____ Please indicate maintenance dose: _____frequency: _____weeks

☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No Has the patient experienced an inadequate response to systemic corticosteroids?

→ ☐ Yes ☐ No Does the patient have an intolerance or contraindication to corticosteroids?

**Immune checkpoint inhibitor-related toxicity**

☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No Does the patient have cardiac toxicity?

**Oligoarticular juvenile idiopathic arthritis/Polyarticular juvenile idiopathic arthritis (p1JIA)**

Please indicate loading dose at weeks 0, 2 and 4:_____ Please indicate maintenance dose: _____frequency: _____weeks

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active articular juvenile idiopathic arthritis?

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) that is indicated for moderately to severely active articular juvenile idiopathic arthritis?

→ ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration?

→ ☐ Yes ☐ No Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)?

→ ☐ Yes ☐ No Does the patient have one of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease?

☐ Yes ☐ No Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage?

☐ Yes ☐ No Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease?

**Prophylaxis of acute graft versus host disease**

☐ Yes ☐ No Is the patient at least 2 years of age and less than 6 years of age?

→ ☐ Yes ☐ No Does the prescribed dose exceed 15 mg/kg on the day before transplantation followed by 12 mg/kg on Days 5, 14, and 28 after transplantation?

☐ Yes ☐ No Is the patient 6 years of age or older?

→ ☐ Yes ☐ No Does the prescribed dose exceed 10 mg/kg (maximum 1000 mg) on the day before transplantation and on Days 5, 14, and 28 after transplantation?

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?

☐ 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**

Please indicate loading dose at weeks 0, 2 and 4:_____ Please indicate maintenance dose: _____frequency: _____weeks

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?

☐ Yes ☐ No Has the patient been diagnosed with active psoriatic arthritis (PsA)?

Please indicate the preferred alternatives for psoriatic arthritis that have been ineffective, not tolerated, or are contraindicated: ☐ Inflectra ☐ Simponi Aria

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**G. CLINICAL INFORMATION -** Required clinical information must be completed for ALL precertification requests.

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic arthritis?

- ☐ Yes ☐ No Does the patient have mild to moderate disease?
  - ☐ Yes ☐ No Does the patient have severe disease?
- ☐ Yes ☐ No Does the patient have enthesitis or predominantly axial disease?
  - ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration?
    - ☐ Yes ☐ No Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)?
      - ☐ Yes ☐ No Does the patient have a contraindication to methotrexate or leflunomide?
        - ☐ Yes ☐ No Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)?
    - Please indicate the contraindication:
      - ☐ History of intolerance or adverse event ☐ Renal impairment
      - ☐ Hypersensitivity ☐ Breastfeeding ☐ Elevated liver transaminases
      - ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
      - ☐ Myelodysplasia ☐ Pregnancy or currently planning pregnancy
      - ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis
      - ☐ Significant drug interaction
      - ☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
      - ☐ Other: _____

**Rheumatoid arthritis**

Please indicate loading dose at weeks 0, 2 and 4:_____ Please indicate maintenance dose: _____frequency: _____weeks

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis?

- ☐ Yes ☐ No Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive?
  - ☐ Yes ☐ No Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)?
- ☐ Yes ☐ No Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week?
  - ☐ Yes ☐ No Has the patient experienced an intolerance to methotrexate?
    - ☐ Yes ☐ No Does the patient have a contraindication to methotrexate?
    - Please indicate the contraindication:
      - ☐ History of intolerance or adverse event ☐ Renal impairment ☐ Hypersensitivity
      - ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
      - ☐ Breastfeeding ☐ Elevated liver transaminases ☐ Myelodysplasia
      - ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis
      - ☐ Pregnancy or currently planning pregnancy ☐ Significant drug interaction
      - ☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
      - ☐ Other: _____

Please indicate the preferred alternatives that have been ineffective, not tolerated, or are contraindicated (one month trial each): ☐ Inflectra ☐ Simponi Aria

**For Continuation Requests (clinical documentation required for all requests):**

Please indicate maintenance dose: _____frequency: _____weeks

☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

**Chronic graft versus host disease**

☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

☐ Yes ☐ No Has the patient experienced an inadequate response to systemic corticosteroids?

- ☐ Yes ☐ No Does the patient have an intolerance or contraindication to corticosteroids?

**Immune checkpoint inhibitor-related toxicity**

☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

☐ Yes ☐ No Does the patient have cardiac toxicity?

***Continued on next page***

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## G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

**Oligoarticular juvenile idiopathic arthritis/Polyarticular juvenile idiopathic arthritis (pJIA)**

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

→ Please indicate which of the following has the patient experienced:

☐ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion) ☐ Number of joints with limitation of movement

☐ Functional ability ☐ None of the above

**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?

***For 2 years to less than 6 years of age only:***

Please indicate the prescribed dose on the day before transplantation: _____ mg

☐ Yes ☐ No Does the prescribed dose exceed 15 mg/kg on the day before transplantation?

Please indicate dose on day Days 5, 14, and 28 after transplantation: _____ mg

☐ Yes ☐ No Does the prescribed dose exceed 12 mg/kg on Days 5, 14, and 28 after transplantation?

***For 6 years of age or older only:***

Please indicate the prescribed dose on the day before transplantation: _____ mg

☐ Yes ☐ No Does the prescribed dose exceed 10 mg/kg (maximum 1000 mg) on the day before transplantation?

Please indicate dose on day Days 5, 14, and 28 after transplantation: _____ mg

**Psoriatic arthritis**

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

→ Please indicate which of the following has the patient experienced:

☐ Number of swollen joints ☐ Number of tender joints ☐ Dactylitis ☐ Enthesitis ☐ Skin and/or nail involvement ☐ None of the above

**Rheumatoid arthritis**

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?

→ ☐ Yes ☐ No Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability?

→ Please indicate the percent of substantial disease activity improvement in tender joint count, swollen joint count, pain, or disability: _____ %

## 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.