Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

ORENCIA
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty: □ Rheumatologist □ Other:_____
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Orencia	□ 125mg/ml Pre-Filled Syringe □ 250mg Powder Vial (IV)			

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** delivered to the member *or* provider for administration. Specialty Pharmacy:_____	□ Billed under **MEDICAL** benefit by provider. JCODE: J0129_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Diagnosis: □ Juvenile Idiopathic Arthritis □ Rheumatoid Arthritis □ Other_____

Date of Diagnosis:_____ Height:_____ Weight:_____

Disease Severity:
□ Mild
□ Moderate
□ Severe

PPD (tuberculin) test:
□ Positive
□ Negative
Date:_____

Is the member currently using another TNF-blocking or biologic agent in combination with Orencia? □ Yes □ No
Medication:_____

Does the member currently have evidence of infection? □ Yes □ No

Please indicate past medication(s) tried for at *least 3 months* and failed:

Medication	Start Date	End Date	Strength	Frequency	Reason for Discontinuing
□ Methotrexate					
□ Hydroxychloroquine (Plaquenil)					

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

☐ Leflunomide (Arava)					
☐ Minocycline (Minocin)					
☐ Sulfasalazine (Azulfidine)					
☐ **ENBREL****					
☐ **HUMIRA****					
☐ Remicade					
☐ Simponi					
☐ Cimzia					
☐ Other: _____					

Please provide any additional information which should be considered in the space below: