Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	_____/_____/_____ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Orencia IV**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process*.

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with questionset.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Site of Care:

A. At what location will the member be receiving the requested medication?

❑ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.

❑ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting.

_____

❑ Other. Please specify. _____

NOTE: Form must be completed in its **entirety** for processing

Criteria Questions:

1. Is this **INITIATION** of Orencia therapy? ***Please select answer below:***
   - ❑ **NO** – this is a PA renewal for **CONTINUATION** of therapy, please answer questions on **continuation section.**
   - ❑ **YES –** this is **INITIATION** of therapy, please answer the following questions:

2. What is the patient's diagnosis?
   - ❑ Juvenile Rheumatoid Arthritis (JRA) / Polyarticular Juvenile Idiopathic Arthritis (pJIA)
     a. Is the patient's arthritis active? ❑ Yes ❑ No
     b. What is the patient's weight? ***Please select answer below:***
        - ❑ **Less than 75 kg (165 lbs)**
          Does the prescriber agree to administer the medication within the FDA labeled dose of 10mg per kg every four weeks?
          ❑ Yes ❑ No
        - ❑ **75 kg (165 lbs) to 100kg (220 lbs)**
          Does the prescriber agree to administer the medication within the FDA labeled dose of 750mg every four weeks?
          ❑ Yes ❑ No
        - ❑ **Greater than 100 kg (220 lbs)**
          Does the prescriber agree to administer the medication within the FDA labeled dose of 1000mg every four weeks?
          ❑ Yes ❑ No
   - ❑ Psoriatic Arthritis (PsA)
     a. Does the patient have active psoriatic arthritis? ❑ Yes ❑ No ***Please also answer weight question below.***
        ❑ Rheumatoid Arthritis (RA)
     b. Does the patient have moderate to severely active rheumatoid arthritis? ❑ Yes ❑ No ***Please also answer weight question below.***

     IF PsA / RA: What is the patient's weight? ***Please select answer below***
        - ❑ **Less than 60 kg (132 lbs)**
          Does the prescriber agree to administer the medication within the FDA labeled dose of 500mg every four weeks?
          ❑ Yes ❑ No
        - ❑ **60 kg (132 lbs) to 100kg (220 lbs)**
          Does the prescriber agree to administer the medication within the FDA labeled dose of 750mg every four weeks?
          ❑ Yes ❑ No
        - ❑ **Greater than 100 kg (220 lbs)**
          Does the prescriber agree to administer the medication within the FDA labeled dose of 1000mg every four weeks?
          ❑ Yes ❑ No
   - ❑ Other diagnosis ***(please specify):*** _____

3. Does the patient have a contraindication to at least one conventional disease-modifying antirheumatic drug (DMARD)? ❑Yes ❑No*
   ****If NO***, has the patient experienced an inadequate treatment response or intolerance to at least a three month trial of at least one conventional DMARD?
   ❑ Yes ❑ No

4. Does the patient have a contraindication to or have they had either an inadequate treatment response or intolerance to biologic DMARD or a targeted synthetic DMARD? ❑ Yes ❑ No

5. Has the patient had a TB test to rule out tuberculosis (TB)? ❑ Yes* ❑ No
   ****If YES***, what was the result of the TB test? ❑ Negative ❑ Positive*
   ****If POSITIVE***, is the patient currently receiving treatment or has the patient already completed treatment for the TB infection? ❑ Yes ❑ No

6. Is the patient at risk for a Hepatitis B Virus (HBV) infection? ❑ Yes* ❑ No
   ****If YES***, has the HBV infection been ruled out or has the patient already started treatment for the HBV infection? ❑ Yes ❑ No

7. Does the patient have any active infections including TB and HBV? ❑ Yes ❑ No

8. Will the patient be given live vaccines while on Orencia therapy? ❑ Yes ❑ No

9. Will Orencia be given in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑ Yes* ❑ No
   ****If YES***, please specify:

   _____

DMARDs include: Actemra, Cimzia, Costentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Stelara, Taltz Tremfya, and Xeljanz

CONTINUATION OF ORENCIA INTRAVENOUS THERAPY (PA RENEWAL)

1. Is this a PA renewal for **CONTINUATION** of Orencia therapy? ***Please select answer below:***
   - ❑ **NO** – this is **INITIATION** of therapy, please answer questions on **initiation section.**
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

2. What is the patient's diagnosis?
   - ❑ Juvenile Rheumatoid Arthritis (JRA) / Polyarticular Juvenile Idiopathic Arthritis (pJIA)
     a. What is the patient's weight? ***Please select answer below:***
        - ❑ **Less than 75 kg (165 lbs)**
          Does the prescriber agree to administer the medication within the FDA labeled dose of 10mg per kg every four weeks?
          ❑ Yes ❑ No
        - ❑ **75 kg (165 lbs) to 100kg (220 lbs)**
          Does the prescriber agree to administer the medication within the FDA labeled dose of 750mg every four weeks?
          ❑ Yes ❑ No
        - ❑ **Greater than 100 kg (220 lbs)**
          Does the prescriber agree to administer the medication within the FDA labeled dose of 1000mg every four weeks?
          ❑ Yes ❑ No
   - ❑ Psoriatic Arthritis (PsA) ***Please also answer weight question below.***
   - ❑ Rheumatoid Arthritis (RA) ***Please also answer weight question below.***
     IF PsA / RA: What is the patient's weight? ***Please select answer below:***
     - ❑ **Less than 60 kg (132 lbs)**
       Does the prescriber agree to administer the medication within the FDA labeled dose of 500mg every four weeks?
       ❑ Yes ❑ No
     - ❑ **60 kg (132 lbs) to 100kg (220 lbs)**
       Does the prescriber agree to administer the medication within the FDA labeled dose of 750mg every four weeks?
       ❑ Yes ❑ No
     - ❑ **Greater than 100 kg (220 lbs)**
       Does the prescriber agree to administer the medication within the FDA labeled dose of 1000mg every four weeks?
       ❑ Yes ❑ No
   - ❑ Other diagnosis ***(please specify):*** _____

3. Has the patient's condition improved or stabilized with Orencia? ❑ Yes ❑ No

4. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑ Yes ❑ No

5. Will the patient be given live vaccines while on Orenica? ❑ Yes ❑ No

6. Will Orencia be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑ Yes* ❑ No
   If YES, please specify: _____

DMARDs include: Actemra, Cimzia, Costentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Stelara, Taltz Tremfya, and Xeljanz

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**
Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox** **1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program** **P.O. Box 312320, Detroit, MI 48231-2320**