

Orencia® (abatacept) Injectable Medication Precertification Request

Page 1 of 4

(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 to			,			
	tion of therapy, date of las	st treatment:/			F	
Precertification Requested E	oy:		Phone:		Fax:	
A. PATIENT INFORMATION First Name:		Last Name:			DOB:	
						ZID.
Address:		City:	0 11 01		State:	ZIP:
Home Phone:	Work Phone:		Cell Phone:		Email:	
Patient Current Weight:		ent Height: inches	s or cms Allergi	es:		
B. INSURANCE INFORMATIO						
Aetna Member ID #:		Does patient have other		_		
Group #: Insured:		Insured:	Ca	mer nam	e:	
Medicare: ☐ Yes ☐ No If	ves, provide ID #:		dicaid: Yes No I	f yes, pro	vide ID #:	
C. PRESCRIBER INFORMATI				, , ,		
First Name:		Last Name:	(Che	ck one):	☐ M.D. ☐ D.C). N.P. P.A.
Address:		<u> </u>	City:		State:	ZIP:
Phone:	Fax:	St Lic #:	1	DEA #:		UPIN:
Provider Email:		Office Contact Name:			Phone:	1 -
Specialty (Check one): O	ncologist	ologist Other:				
D. DISPENSING PROVIDER/A						
Self-administered □ Physician's Office □ Outpatient Infusion Center Phone: Center Name: □ Home Infusion Center Phone: Agency Name: □ □ Administration code(s) (CPT): Address:			☐ Physician's Office ☐ Retail Pharmacy ☐ Specialty Pharmacy ☐ Other: Name:			
E. PRODUCT INFORMATION						
Request is for: Orencia (aba	tacept) Dose:		Frequency:			
F. DIAGNOSIS INFORMATION	N - Please indicate primary I	CD code and specify any	other any other where app	licable (*)		
	DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*). rimary ICD Code: Other ICD Code:					
G. CLINICAL INFORMATION	- Required clinical information	on must be completed for	ALL precertification reques	sts.		
☐ Yes ☐ N☐ Yes ☐ Yes ☐ N☐ Yes ☐	request in an outpatient hos o Has the patient experien (e.g., acetaminophen, st anaphylactoid reactions, o Does the patient have so outpatient hospital settin o Does the patient have si infusion therapy AND the Please provide a descrip o Is the patient medically u member's ability to tolera	spital setting? loced an adverse event wit leroids, diphenhydramine, l	, fluids, other pre-medication romboembolism, or seizure uses that require the use of sees and/or physical or cogniticates to a caregiver? use or impairment:	ns) or a so s) during of special inte ive impairs lar, or rena r to a seve equipment	evere adverse ever immediately afterventions only aver ment that would in all conditions that ere adverse even ?	ent (anaphylaxis, er an infusion? vailable in the mpact the safety of the may limit the that cannot be
1		Ш'	Other:			-

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB	
G. CLINICAL INFORMATION (continued)	Required clinical information must be completed.	eted in its <u>entirety</u> for all precertif	ication requests.	
☐ Yes ☐ No Will the requested drug be☐ Yes ☐ No Has the patient ever receive with an increased risk of to☐ Yes ☐ No Has the p	used in combination with any other biologic (e. ved (including current utilizers) a biologic (e.g.,	g., Humira) or targeted synthetic Humira) or targeted synthetic dru	drug (e.g., Olumiant, Otezla, Xeljanz)? ıg (e.g., Olumiant, Xeljanz) associated	
(Check al Please er If positiv : ☐ latent	I that apply): ☐ PPD test ☐ interferon-gamm. Iter the results of the tuberculosis (TB) test: ☐ Iter the results of the tuberculosis (TB) test: ☐ Iter the results of the tuberculosis (TB) test: ☐ Iter the results of the tuberculosis (TB) test ☐ Iter that the results of the tuberculosis (TB) that the tuberculosis (TB) and treatment for latent TB has been complete.	positive ☐ negative ☐ unkno	wn	
☐ latent ☐ active	TB and treatment for latent TB has not been ini TB	tiated		
For Initiation Requests (clinical document				
Chronic graft versus host disease	and 4: Please indicate maintenance d	essa fraguenava	weeks	
	upported by dosing guidelines found in the com			
-	g prescribed by or in consultation with an oncoled an inadequate response to systemic corticos			
Yes No Does the	patient have an intolerance or contraindication			
Immune checkpoint inhibitor-related tox	cicity upported by dosing guidelines found in the com	anandia ar aurrant litaratura (a.g.	Micromodov DrugDov, NCCN	
compendia, current treatm	ent guidelines)?		, Micromedex DrugDex, NCCN	
Yes No Does the patient have care	g prescribed by or in consultation with an oncol diac toxicity?	ogist or hematologist?		
Oligoarticular juvenile idiopathic arthriti	s/Polyarticular juvenile idiopathic arthritis (ן	o1JIA)		
Please indicate loading dose at weeks 0, 2	and 4: Please indicate maintenance	dose:frequency:	weeks	
	nosed with moderately to severely active articul			
☐ 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?				
└────────────────────────────────────	atient had an inadequate response to methotre ine, hydroxychloroquine) administered at an ac		thetic drug (e.g., leflunomide,	
└────────────────────────────────────	No Has the patient had an inadequate responsible (NSAIDs) and/or intra-articular glucocort			
		iac joint, and/or temporomandibເ	or poor outcome: a) involvement of ular joint (TMJ), b) presence of erosive levels of inflammation markers, or	
□ Voc □ No. Doos the petient house any	e) symmetric disease?			
rheumatoid factor, b) posit	of the following risk factors for disease severity ive anti-cyclic citrullinated peptide antibodies, or	r c) pre-existing joint damage?		
☐ Yes ☐ No Does the patient meet any c) high risk for disabling jo	of the following: a) high-risk joints are involved int disease?	(e.g., cervical spine, wrist, or hip	b), b) high disease activity, or	
Prophylaxis of acute graft versus host of Yes No Is the patient at least 2 years.				
☐ Yes ☐ No Does the	prescribed dose exceed 15 mg/kg on the day better transplantation?	efore transplantation followed by	12 mg/kg on Days 5, 14,	
Yes No Is the patient 6 years of ag	e or older? prescribed dose exceed 10 mg/kg (maximum 1 er transplantation?	000 mg) on the day before trans	plantation and on Days 5, 14,	
	g prescribed by or in consultation with an oncol	ogist or hematologist?		
☐ Yes ☐ No Will the requested medical	ematopoietic stem cell transplantation (HSCT) ion be used in combination with a calcineurin ir			
Psoriatic arthritis	and 4. Disease to disease or shot	dana. <i>f</i>		
	and 4: Please indicate maintenance g prescribed by or in consultation with a rheumann process.		weeks	
☐ Yes ☐ No Has the patient been diagr Please indicate the preferred alternatives for	nosed with active psoriatic arthritis (PsA)? or psoriatic arthritis that have been ineffective, r	not tolerated, or are contraindica	ted: 🗌 Inflectra 🔲 Simponi Aria	

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C. CLINICAL INFORMATION - Required directal information must be completed for ALL procedification requests. No No No Deas the patient aver received (including current utilizers) a biologic (e.g., Humira) or targeted symhetic drug (e.g., Rinvoq, Otezla) that is indicated for active portatic attribits? No Deas the patient have entheatits or predominantly axial disease? Yes No Deas the patient have entheatits or predominantly axial disease? Yes No Deas the patient have entheatits or predominantly axial disease? Yes No Deas the patient have entheatits or predominantly axial disease? Yes No Deas the patient have in an inadequate response to methotrexate or felhoromide, or another conventional synthetic drug (e.g., sulfisalazine)? Yes No Deas the patient have a contraindication to methotrexate or felhoromide? Yes No Deas the patient have a contraindication to methotrexate or felhoromide? Yes No Deas the patient have a contraindication to another conventional synthetic drug (e.g., sulfisalazine)? Yes No Deas the patient have a contraindication to another conventional synthetic drug (e.g., sulfisalazine)? Yes No Deas the patient have a contraindication to another conventional synthetic drug (e.g., sulfisalazine)? Yes No Deas the patient have a contraindication to another conventional synthetic drug (e.g., sulfisalazine)? Yes No Deas the patient have a contraindication to methotrexate or fellowore in the patient have a contraindication to another conventional synthetic drug (e.g., sulfisalazine)? Yes No Secondary Pelease indicate the contraindication is patient have a contraindication in the patient have a contraindication. Yes No Secondary Pelease indicate the contraindicate in the patient have a contraindication of the patient have a contraindication to methotrexate and the after a contraindication of the pat	Patient First Name	Patient Last Name	Patient Phone	Patient DOB	
No Nas the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezia) that is inclinated for active positios 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 be patient have severe disease? Yes No Does the patient have intended to the patient have been intended to the patient have been contraindication to methotrexate or leftunomide? Yes No Does the patient have a contraindication to another year intended to the patient have a contraindication to another year intended to the patient have a contraindication to another History of intolerance or adverse event Benatic hardward intended to the patient have a contraindication to another History of intolerance or adverse event Benatic hardward Benati					
Indicated for active psorialic arthrits' Indicated for moderated psorialic arth	G. CLINICAL INFORMATION - Requ	rired clinical information must be complete	ed for ALL precertification requests		
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drug (e.g., sulfasalazine) administered at an adequate dose and duration? Ves No Nest be patient had an iniclorance to methotroxate, lefturomide, or another conventional synthetic drug (e.g., sulfasalazine)? Ves No Does the patient have a contraindication to methotrex are very to 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 dyscrasials (e.g., thrombocytopenia, leukopenia, significant anemia) Myelodysplasia Prepancy or currently planning prepancy History of intolerance or adverse event Renal impairment Hypersensitivity Breastfeeding Elevated liver transaminases Blood dyscrasials (e.g., thrombocytopenia, leukopenia, significant anemia) Myelodysplasia Prepancy or currently planning prepancy Interestitial pneumonitis or cilinically significant pulmonary fibrosis Significant drug interaction Circleration Circle	l l	·	•		-4:-
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Yes No Does the patient have a contraindication to methorsake or lefluronide?		Yes No Has the pati	ent had an intolerance to methotre:		I
				undication to mothetrovate or leftunemide?)
History of Intolerance or adverse event. Renal impairment Hypersensitivity Greastfeeding Elevated liver transaminases Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) Myelodysplasia Pregnancy or currently planning pregnancy Interstitial pneumonits or clinically significant pulmonary fibrosis Significant drug interaction Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease No Chinest C	Yes No Does the patient have a contraindication to another				
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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:					
Significant drug interaction Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease indicate loading dose at weeks 0, 2 and 4: Please indicate maintenance dose: frequency: weeks Yes					
Rheumatoid arthritis Please indicate loading dose at weeks 0, 2 and 4:			· · · · · · · · · · · · · · · · · · ·	ıt pulmonary fibrosis	
Chronic liver disease Other: Chronic liver disease Chronic liver diversel liver liver lead to the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?			•	coholic liver disease or other	
Please indicate loading dose at weeks 0, 2 and 4:				deficite liver disease of earler	
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 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? Indicated for moderately to severely active rheumatoid arthritis? 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? 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 Does the patient have a contraindication to methotrexate? History of intolerance or adverse event Renal impairment Hypersensitivity Blood dyscrasias (e.g., thromboeytopenia, 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: Pregnancy or currently planning pregnancy Significant drug interaction Simponi Aria For Continuation Requests (clinical documentation required for all requests); Please indicate the preferred alternatives that have been ineffective, not tolerated, or are contraindicated (one month trial each): Inflectra Simponi Aria For Continuation Requests		Other:			
Ves No No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)? Ves No Is the requested drug being prescribed by or in consultation with a rheumatologist? Ves No Is the requested drug being prescribed by or in consultation with a rheumatologist? Ves No Is the requested drug being prescribed by or in consultation with a rheumatologist? Ves No Is 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? Ves 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? Ves No Has the patient been tested for all of the following biomarker: a) theumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP) biomarker test was positive? Ves No Has the patient been tested for all of the following biomarker: a) theumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP) biomarker test was positive? Ves No Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate (ESR)? Ves No Has the patient experienced an intolerance to methotrexate? Ves No Does the patient have a contraindication to methotrexate? Ves No Biod dyscrasias (e.g., thrombocytopenia, isignificant anemia) 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 giver disease Clinical diagnosis of alcohol use disord		- 0 2 and 4. Blacks indicate many			
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? No Has the patient test was positive? 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 Does 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 Does the patient experienced an intolerance to methotrexate? Yes No Has the patient experienced an intolerance to methotrexate? Yes No Does the patient experienced an 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 drug interaction Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease Other: Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic patient and the patient term of the patient than of the patient term of the patient term of the patient than of the patient term of unifical cortic response to systemic corticosteroids? Immune checkpoint inhibitor-related toxicit				mcyweeks	
Yes			* *		
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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)? It was not 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)? It was not all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP) in the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP) and c) citrullinated peptide (anti-CCP) in the following biomarker and the anti-CCP biomarker test was positive? 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 Septiment or a patient or a patient or anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or a function or the north or than or equal to 15 mg per week? Yes No Septiment or a patient or anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or a function or anti-cyclic citrullinated peptide (anti-CCP) and or a function to contraindicated (one month trial each): Inflectra Simponi Aria				oumatoid factor (PE) biomarker and the Pi	_
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)? 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 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 or other chronic liver disease Other: Please indicate maintenance dose: frequency: weeks Please indicate maintenance dose: frequency: weeks 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? 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 quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?					
citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? Yes	anti-	CCP biomarker test was positive?			
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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 Does the patient experienced an inadequate response to systemic 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)?					
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:					
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 Does the patient have an intolerance or contraindication to corticosteroids? Immune checkpoint inhibitor-related toxicity 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)?					
Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease Other:					
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 Does the patient experienced an inadequate response to systemic corticosteroids? Immune checkpoint inhibitor-related toxicity Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?					
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:					
Please indicate maintenance dose:frequency:weeks \[\text{Yes} \] No \[\text{Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?} \[\text{Chronic graft versus host disease} \] \[\text{Yes} \] No \[\text{Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?} \[\text{Yes} \] No \[\text{No Does the patient experienced an inadequate response to systemic corticosteroids?} \] \[\text{Immune checkpoint inhibitor-related toxicity} \] \[\text{Yes} \] No \[\text{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 patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? Chronic graft versus host disease 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? 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 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)? 			amples or a manufacturer's patient	assistance program?	
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 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)? 	compendia, current treatment guidelines)?				
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)?					
compendia, current treatment guidelines)?	Immune checkpoint inhibitor-related toxicity				
Yes No Does the patient have cardiac toxicity?					



Orencia® (abatacept) Injectable Medication Precertification Request

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(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

Patient First Name	Patient Last Name	Patient Phone	Patient DOB	
G. CLINICAL INFORMATION - Required	clinical information must be completed fo	r 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 dis				
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 □ 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				
swollen join	ient experienced substantial disease activity it count, pain, or disability? cate the percent of substantial disease activit	improvement (e.g., at least 20%	from baseline) in tender joint count,	
H. ACKNOWLEDGEMENT				
Request Completed By (Signature Requ	uired):		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.