Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

# Orencia vial (intravenous)
## (abatacept / maltose)

| PHYSICIAN INFORMATION | | | PATIENT INFORMATION | | |
|---|---|---|---|---|---|
| * Physician Name: | | | *Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.* | | |
| Specialty: | * DEA, NPI or TIN: | | | | |
| Office Contact Person: | | | * Patient Name: | | |
| Office Phone: | | | * Cigna ID: | * Date of Birth: | |
| Office Fax: | | | * Patient Street Address: | | |
| Office Street Address: | | | City: | State: | Zip: |
| City: | State: | Zip: | Patient Phone: | | |

**Urgency:**
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

**Medication requested:**
☐ Orencia 250mg vial

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:
What is your patient's current weight?
What is the requested dose in mg/kg?

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."
☐ new start ☐ continuation of therapy

(if continuation of therapy, if GvHD) Please provide support for continued use including how many total doses the patient has received.

(if continuation of therapy, if PJIA, PsA, RA) Has a beneficial response to this medication been demonstrated? ☐ Yes ☐ No

(if no to any diagnosis) Please provide clinical support for continued use of Orencia.

*(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g., cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)*

**Where will this medication be obtained?**
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

**Facility and/or doctor dispensing and administering medication:**
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

**Where will this drug be administered?**
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

**Diagnosis related to use (please specify):**

☐ Ankylosing spondylitis (AS, axial spondyloarthropathy)
☐ Graft-Versus-Host Disease (GvHD)
☐ Inflammatory bowel disease [Crohn's Disease (CD, regional enteritis), Ulcerative Colitis (UC)]
☐ Polyarticular Juvenile Idiopathic Arthritis (includes juvenile idiopathic arthritis [JIA] or juvenile rheumatoid arthritis [JRA])
☐ Psoriatic Arthritis (PsA)
☐ Psoriasis
☐ Rheumatoid Arthritis (RA)
☐ other (please specify):

**Clinical Information:**

Besides the medication being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Actemra, adalimumab (Humira and all biosimilars), Adbry, Bimzelx, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, infliximab (Remicade and all biosimilars), Kevzara, Kineret, Litfulo, Olumiant, Omvoh, Otezla, Rinvoq, rituximab (Rituxan and all biosimilars), Siliq, Simponi Aria, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tysabri, Velsipity, Xeljanz, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic or tsDMARD at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using.
☐ The patient is currently on another biologic or tsDMARD, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic or tsDMARD, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biologic or tsDMARD.
☐ other/unknown

(if other/more than the requested drug) Please provide rationale for concurrent use.

Is there documentation that your patient either has had failure or is intolerant to any of the following? (check all that apply):
☐ Adalimumab Product: Adalimumab-adaz/Hyrimoz (by Sandoz/Novartis)
☐ Adalimumab Product: Adalimumab-adbm/Cyltezo
☐ Adalimumab Product: Adalimumab-ryvk/Simlandi,
☐ Adalimumab Product: Humira (by AbbVie)
☐ Actemra (subcutaneous)
☐ Cimzia
☐ Cosentyx
☐ Enbrel
☐ Otezla
☐ Rinvoq
☐ Skyrizi (subcutaneous)
☐ Stelara (subcutaneous)
☐ Taltz
☐ Tremfya
☐ Xeljanz
☐ Xeljanz XR
☐ Xeljanz Oral Solution
☐ Other

Please provide drug name(s), date(s) taken and what the documented results were for each drug tried:

Is there documentation that your patient has a contraindication for any of the following? (check all that apply):
☐ Adalimumab Product: Adalimumab-adaz/Hyrimoz (by Sandoz/Novartis)
☐ Adalimumab Product: Adalimumab-adbm/Cyltezo
☐ Adalimumab Product: Adalimumab-ryvk/Simlandi,
☐ Adalimumab Product: Humira (by AbbVie)
☐ Actemra (subcutaneous)
☐ Cimzia
☐ Cosentyx
☐ Enbrel
☐ Otezla
☐ Rinvoq
☐ Skyrizi (subcutaneous)
☐ Stelara (subcutaneous)
☐ Taltz
☐ Tremfya
☐ Xeljanz
☐ Xeljanz XR
☐ Xeljanz Oral Solution
☐ Other

Please provide drug name(s), date(s) taken and what the documented results were for each drug tried:

(if GvHD) Is this medication being used for the prevention of acute graft-versus-host disease? ☐ Yes ☐ No

(if GvHD) Will the patient also receive a calcineurin inhibitor (for example, cyclosporine and tacrolimus) for prevention of acute graft-versus-host disease? ☐ Yes ☐ No

(if GvHD) Will the patient also receive methotrexate for prevention of acute graft-versus-host disease? ☐ Yes ☐ No

(if GvHD) Will the patient undergo hematopoietic stem cell transplantation from a matched unrelated donor? ☐ Yes ☐ No

(if no) Will the patient undergo hematopoietic stem cell transplantation from a 1-allele-mismatched unrelated donor? ☐ Yes ☐ No

(if GvHD) Is this medication being prescribed by, or in consultation with, an oncologist or hematologist? ☐ Yes ☐ No

(if JIA) Is this medication being prescribed by, or in consultation with a rheumatologist? ☐ Yes ☐ No

(if PsA) Is this medication being prescribed by, or in consultation with, a rheumatologist or dermatologist? ☐ Yes ☐ No

(if PsA) Has your patient already tried a biologic or targeted synthetic DMARD (tsDMARD) for Psoriatic Arthritis? ☐ Yes ☐ No

(if PsA) Does your patient primarily have axial disease –OR- non-axial disease?
☐ Non-axial disease
☐ Axial disease

(if non-axial disease) The covered alternative is one disease-modifying anti-rheumatic drug (DMARD). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if non-axial disease) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried one DMARD, but it didn't work.
☐ The patient tried ALL DMARDs, but they did not tolerate each one
☐ The patient cannot try ANY DMARDs because of a contraindication to each of these drugs.
☐ Other

(if axial disease) The covered alternative is one disease-modifying anti-rheumatic drug (DMARD), or a nonsteroidal anti-inflammatory drug (NSAID). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if axial disease) Per the information provided above, which of the following is true for your patient in regard to the covered alternatives?
☐ The patient tried ONE DMARD or NSAID, but it didn't work.
☐ The patient tried ALL DMARDs AND NSAIDs, but had an intolerance to all of these drugs.
☐ The patient can’t try ANY DMARDs or NSAIDs because of a contraindication to each of these drugs.
☐ Other

(if RA) Is this medication being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if RA) Has your patient already tried a biologic or targeted synthetic DMARD (tsDMARD) for Rheumatoid Arthritis? ☐ Yes ☐ No

(if RA) The covered alternative is one DMARD (disease-modifying anti-rheumatic drugs). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has not tried this drug, please provide details why your patient can’t try this alternative.

(if RA) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried one DMARD, but it didn't work.
☐ The patient tried ALL DMARDs, but they did not tolerate each one
☐ The patient cannot try ANY DMARDs because of a contraindication to each of these drugs.
☐ Other

**Additional pertinent information:** *Please include any alternatives tried, with drug name, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:**_____ **Date:**_____

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