BlueCross BlueShield
Federal Employee Program

ORENCIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients Actemra SC including preferred Actemra SC biosimilars, Enbrel, Humira including preferred Humira biosimilars, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/ Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Orencia (abatacept)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

1. **Will this medication be given by IV infusion (solution request) or by subcutaneous (SC, subQ, SQ, or subcut) injection (pen/syringe request)? *Please select answer below:***

❑**IV infusion:** Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Select answer below:***

❑**NO –** this is **INITIATION** of therapy, please answer the questions on **PAGES 2-3**

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 4**

❑**SC injection:** Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Select answer below:***

❑**NO –** this is **INITIATION** of therapy, please answer questions on **PAGES 5-6**

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer questions on **PAGES 7-8**

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
SUBCUTANEOUS INJECTION REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES PAGE 9 TO BE COMPLETED

BlueCross BlueShield
Federal Employee Program

ORENCIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients Actemra SC including preferred Actemra SC biosimilars, Enbrel, Humira including preferred Humira biosimilars, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/ Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Orencia IV Infusion (abatacept)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**YES** – this is **CONTINUATION** of therapy, please answer the questions on **PAGE 4**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient had a tuberculin skin test conducted to rule out tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for TB? ❑Yes ❑No
4. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑No
   If YES, has HBV infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No
5. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No
6. Will the patient be given live vaccines while on Orencia? ❑Yes ❑No
7. Will Orencia be used in combination with another biologic *disease-modifying anti-rheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   ****DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.***
8. What is the patient's diagnosis?
   ❑Prophylaxis of acute Graft Versus Host Disease (aGVHD)
   a. Will the patient be undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated-donor? ❑Yes ❑No
   b. What is the patient's age? ***Please select answer below:***
   ❑**Age 2-5**: Does the prescriber agree not to exceed the FDA labeled dose of 15mg/kg on the day before transplantation (Day -1), then 12mg/kg on Days 5, 14, and 28 after transplantation? ❑Yes ❑No
   ❑**Age 6 or older:** Does the prescriber agree not to exceed the FDA labeled dose of 10mg/kg, with a maximum dose of 1,000mg, on the day before transplantation (Day -1), then Days 5, 14, and 28 after transplantation? ❑Yes ❑No
   c. Will Orencia be used in combination with a calcineurin inhibitor and methotrexate? ❑Yes ❑No

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

ORENCIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Juvenile Rheumatoid Arthritis (JRA) **OR** ❑Polyarticular Juvenile Idiopathic Arthritis (pJIA)

a. Is the patient's arthritis active? ❑Yes ❑No

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 1000mg every four weeks? ❑Yes ❑No

c. Does the patient have a contraindication to at least one conventional DMARD? ❑Yes ❑No*

***If NO**, does the patient have an intolerance or have they had an inadequate treatment response to a three-month trial of at least one conventional DMARD? ❑Yes ❑No

d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to biologic DMARD or targeted synthetic DMARD? ❑Yes ❑No ***(only applies to claims adjudicated through the pharmacy benefit)***

❑Psoriatic Arthritis (PsA)

a. Is the patient's arthritis active? ❑Yes ❑No

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 1000mg every four weeks? ❑Yes ❑No

c. Does the patient have a contraindication to at least one conventional DMARD? ❑Yes ❑No*

***If NO**, does the patient have an intolerance or have they had an inadequate treatment response to a three-month trial of at least one conventional DMARD? ❑Yes ❑No

d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to biologic DMARD or targeted synthetic DMARD? ❑Yes ❑No ***(only applies to claims adjudicated through the pharmacy benefit)***

❑Rheumatoid Arthritis (RA)

a. Does the patient have moderate to severely active rheumatoid arthritis? ❑Yes ❑No

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 1000mg every four weeks? ❑Yes ❑No

c. Does the patient have a contraindication to at least one conventional DMARD? ❑Yes ❑No*

***If NO**, does the patient have an intolerance or have they had an inadequate treatment response to a three-month trial of at least one conventional DMARD? ❑Yes ❑No

d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to biologic DMARD or targeted synthetic DMARD? ❑Yes ❑No ***(only applies to claims adjudicated through the pharmacy benefit)***

❑Other diagnosis ***(please specify):*** _____

BlueCross BlueShield Federal Employee Program

ORENCIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients Actemra SC including preferred Actemra SC biosimilars, Enbrel, Humira including preferred Humira biosimilars, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/ Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

CONTINUATION OF THERAPY (PA RENEWAL)

Orencia IV Infusion (abatacept)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 2**
   ❑**YES** – this is **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. What is the patient's diagnosis?
   ❑Juvenile Rheumatoid Arthritis (JRA)
   ❑Polyarticular Juvenile Idiopathic Arthritis (pJIA)
   ❑Psoriatic Arthritis (PsA)
   ❑Rheumatoid Arthritis (RA)
   ❑Other diagnosis ***(please specify):*** _____

4. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 1000mg every four weeks? ❑Yes ❑No

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

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

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

8. Will Orencia be used in combination with another biologic *****disease-modifying anti-rheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes***** ❑No
   ****If YES,*** please specify: _____
   ****DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.***

BlueCross BlueShield Federal Employee Program

ORENCIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients, Actemra SC including preferred Actemra SC biosimilars, Enbrel, Humira including preferred Humira biosimilars, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/ Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Orencia Subcutaneous Injection (SC)

(abatacept)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**YES** – this is **CONTINUATION** of therapy, please answer the questions on **PAGE 7**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. What is the patient's diagnosis?

❑Juvenile rheumatoid arthritis (JRA) **OR** ❑Polyarticular juvenile idiopathic arthritis (pJIA)

a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz? ***Please select answer below:***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred medications? ❑Yes* ❑No
If YES, select the preferred medication: ❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz

❑**No**: Would you like to participate in this program and switch the patient to one of the preferred medications? ❑Yes* ❑No
If YES, select the preferred medication: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz

b. Is the patient's arthritis active? ❑Yes ❑No

❑Psoriatic arthritis (PsA)

a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes* ***(*If YES, select the preferred product below)*** ❑No
❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya ❑Xeljanz/Xeljanz XR

b. Does the patient have active psoriatic arthritis (PsA)? ❑Yes ❑No

❑Rheumatoid arthritis (RA)

a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ***Please select answer below***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes* ❑No
If YES, select the preferred product: ❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑**No:** Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes* ❑No
If YES, select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

b. Does the patient have moderate to severely active rheumatoid arthritis (RA)? ❑Yes ❑No

❑Other ***(please specify):*** _____

PLEASE PROCEED TO PAGE 6 FOR ADDITIONAL QUESTIONS

BlueCross BlueShield Federal Employee Program

ORENCIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 6 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

4. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 125mg every week? ❑Yes ❑No

5. Does the patient have a contraindication to at least one conventional disease-modifying anti-rheumatic drug (DMARD)? ❑Yes ❑No*
   ***If NO**, does the patient have an intolerance or have they had an inadequate treatment response to a 3 month trial of at least one conventional disease-modifying anti-rheumatic drug (DMARD)? ❑Yes ❑No

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

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

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

9. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

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

DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
SUBCUTANEOUS INJECTION REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES PAGE 9 TO BE COMPLETED

BlueCross BlueShield Federal Employee Program

ORENCIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients Actemra SC including preferred Actemra SC biosimilars, Enbrel, Humira including preferred Humira biosimilars, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/ Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

CONTINUATION OF THERAPY (PA RENEWAL)
Orencia Subcutaneous Injection (SC)
(abatacept)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 5**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. What is the patient's diagnosis?

❑Juvenile rheumatoid arthritis (JRA) **OR** ❑Polyarticular juvenile idiopathic arthritis (pJIA)

a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz? ***Please select answer below***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred medications? ❑Yes* ❑No

If YES, select the preferred medication: ❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz

❑**No**: Would you like to participate in this program and switch the patient to one of the preferred medications? ❑Yes* ❑No

If YES, select the preferred medication: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz

❑Psoriatic arthritis (PsA)

a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes* ***(*If YES, select the preferred product below)*** ❑No

❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya ❑Xeljanz/Xeljanz XR

❑Rheumatoid arthritis (RA)

a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes* ❑No

If YES, select the preferred product: ❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑**No:** Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes* ❑No

If YES, select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑Other ***(please specify):*** _____

PLEASE PROCEED TO PAGE 8 FOR ADDITIONAL QUESTIONS

BlueCross BlueShield Federal Employee Program

ORENCIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 8 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

4. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 125mg every week? ❑Yes ❑No
5. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
6. Does the patient have any active infections including tuberculosis and hepatitis B virus (HBV)? ❑Yes ❑No
7. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
8. Will Orencia be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No

   If YES, please specify the medication: _____

   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
SUBCUTANEOUS INJECTION REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES PAGE 9 TO BE COMPLETED

BlueCross BlueShield Federal Employee Program

ORENCIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 9 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
SUBCUTANEOUS INJECTION REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS
REQUIRES PAGE 9 TO BE COMPLETED

1. Please select the diagnosis and answer the following questions:

❑**Juvenile rheumatoid arthritis (JRA)/Polyarticular juvenile idiopathic arthritis (pJIA)**

a. Does the patient have an intolerance or contraindication** or have they had an inadequate treatment response to **TWO** of the following preferred medications: Humira or a Humira biosimilar, Actemra SC or an Actemra SC biosimilar, Enbrel, Rinvoq, or Xeljanz? ❑Yes ❑No*

If NO, is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑**Rheumatoid arthritis (RA)**

a. Does the patient have an intolerance or contraindication** or have they had an inadequate treatment response to **TWO** of the following preferred medications: Humira or a Humira biosimilar, Actemra SC or an Actemra SC biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes ❑No*

If NO, is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑**Psoriatic arthritis (PsA)**

a. Does the patient have an intolerance or contraindication** or have they had an inadequate treatment response to **TWO** of the following preferred medications: Humira or a Humira biosimilar, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, or Xeljanz/Xeljanz XR? ❑Yes ❑No*

If NO, is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.