PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D - Orencia (Subcutaneous)

Phone: 1-800-728-7947 Fax back to: 866-880-4532

SCOTT AND WHITE manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		

Drug Name:	☐ Expedited/Urgent
Directions:	

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:

Q1. What diagnosis is this drug being prescribed for (pick one)?

☐ Psoriatic arthritis ☐ Rheumatoid arthritis ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is the prescribing physician a Rheumatologist?

☐ Yes ☐ No

Q4. Is the patient a new start? If no, please specify start date.

☐ Yes, new start

☐ No - continuing prior Orencia subcutaneous therapy (please specify start date)

☐ No - previously on Orencia IV therapy (please specify start date)

Q5. Does the patient have trial and failure, contraindication, or intolerance to any of the following?

☐ Cimzia

☐ Enbrel

☐ Humira

☐ Inflectra, Remicade, or Renflexis

☐ Simponi

Q6. Will the patient be taking Orencia in combination with another biologic disease modifying antirheumatic drug (DMARD) (e.g. Enbrel, Humira, Cimzia, Simponi)?

☐ Yes ☐ No

Q7. Will the patient be taking Orencia in combination with a Janus kinase inhibitor(e.g. Xeljanz)?

☐ Yes ☐ No

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Q8. Additional Comments

Physician Signature **Date**