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?

(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

What is the indication or diagnosis?

☐ 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:

Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic oral small molecule drug?

☐ Biologic (an adalimumab product [Humira, biosimilar], Bimzelx, Cimzia, Cosentyx (IV or SC), etanercept SC product [Enbrel, biosimilar], Entyvio (IV or SC), Ilumya, infliximab IV products [Remicade, biosimilar], Kevzara, Kineret, Omvoh (IV or SC), Orencia [SC], a rituximab IV product [Rituxan, biosimilar], Skyrizi (IV or SC), Siliq, Simponi [Aria or SC]), Taltz, a tocilizumab product [Actemra (IV or SC), biosimilar], Tremfya (IV or SC), an ustekinumab product [Stelara (IV or SC), biosimilar], or Zymfentra.
☐ Targeted synthetic oral small molecule drug (such as Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Velsipity, or Zeposia.)
☐ Conventional synthetic DMARD (such as methotrexate, leflunomide, sulfasalazine, hydroxychloroquine)
☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic oral small molecule drug

Has the patient been established on therapy with Orencia (intravenous or subcutaneous) for at least 6 months? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy. ☐ Yes ☐ No

If Rheumatoid arthritis (RA):

Has the patient experienced an improvement in at least one symptom, such as decreased joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths? ☐ Yes ☐ No

Has the patient tried one conventional synthetic disease-modifying antirheumatic drug (DMARD) (brand or generic; oral or injectable) for at least 3 months? Please Note: Examples of conventional synthetic DMARDs are methotrexate [oral or injectable], leflunomide, sulfasalazine, and hydroxychloroquine). ☐ Yes ☐ No

Has the patient already had a 3-month trial of at least one biologic other than the requested drug? Please Note: A biosimilar of the requested biologic does not count. Examples of biologics include an etanercept product [Enbrel, biosimilars], an adalimumab product [Humira, biosimilars], an infliximab product [Remicade, biosimilars], Kevzara, Simponi [Aria or SC], a tocilizumab product [Actemra IV or SC, biosimilar], Kineret, Cimzia, and a rituximab IV product [Rituxan, biosimilars]. ☐ Yes ☐ No

Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? Please Note: Examples of standardized and validated measures of disease activity include Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS) 28 using erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), Patient Activity Scale (PAS)-II, Rapid Assessment of Patient Index Data 3 (RAPID-3), and/or Simplified Disease Activity Index (SDAI). ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

Has the patient tried ANY of the following? Check ALL that apply. Please Note: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes, prescription claims records, and/or prescription receipts.

☐ an adalimumab product (Examples of adalimumab products include Humira, Abrilada, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, adalimumab-aaty, adalimumab-ryvk, Simlandi, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry. A trial of multiple adalimumab products counts as ONE product.)
☐ Cimzia
☐ Enbrel
☐ an infliximab product (for example, Remicade, biosimilars)
☐ Kevzara
☐ Rinvoq
☐ Simponi (Aria or SC)
☐ tocilizumab subcutaneous product (Examples of tocilizumab subcutaneous products include Actemra subcutaneous and Tyenne subcutaneous. A trial of multiple tocilizumab products counts as ONE product.)
☐ tocilizumab intravenous product (Actemra intravenous, biosimilar) A trial of multiple tocilizumab products counts as ONE product.
☐ Xeljanz/XR (A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as a trial of ONE product.)

If Juvenile Idiopathic Arthritis (JIA) Please Note: This includes JIA regardless of type of onset. JIA is also referred to as Juvenile Rheumatoid Arthritis:

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug)? Please Note: Examples of objective measures include Physician Global Assessment (MD global), Parent/Patient Global Assessment of Overall Well-Being (PGA), Parent/Patient Global Assessment of Disease Activity (PDA), Juvenile Arthritis Disease Activity Score (JDAS), Clinical Juvenile Arthritis Disease Activity Score (cJDAS), Juvenile Spondyloarthritis Disease Activity Index (JSpADA), serum markers (for example, C-reactive protein, erythrocyte sedimentation rate), and/or reduced dosage of corticosteroids. ☐ Yes ☐ No

Compared with baseline (prior to initiating the requested drug), has the patient experienced an improvement in at least one symptom, such as improvement in limitation of motion, less joint pain or tenderness, decreased duration of morning stiffness or fatigue, improved function or activities of daily living? ☐ Yes ☐ No

According to the prescriber, has the patient been established on Orencia IV for at least 90 days? PLEASE NOTE: If the patient has been receiving Orencia (subcutaneous formulation) answer NO to this question. Answer YES only if the patient has been on Orencia IV (intravenous formulation) for at least 90 days. ☐ Yes ☐ No

Does the patient have heart failure, a previously treated lymphoproliferative disorder, a previous serious infection, OR a demyelinating disorder, as determined by the prescriber? ☐ Yes ☐ No

Per the prescriber has the patient has been receiving Orencia SC for at least 90 days? ☐ Yes ☐ No

Per the prescriber has the patient has been receiving Orencia SC via paid claims (for example, patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Orencia SC)? ☐ Yes ☐ No

Has the patient tried one other agent for this condition? Please Note: Examples of therapies which could have been tried include methotrexate, sulfasalazine, or leflunomide, and a nonsteroidal anti-inflammatory drug (NSAID). A biologic (other than the requested drug) also counts as a trial of one agent for JIA. A biosimilar of the requested biologic does not count. Examples of biologics include an adalimumab product [Humira, biosimilars], an etanercept product [Enbrel, biosimilars], an infliximab product [Remicade, biosimilars], Kineret [anakinra SC injection], a tocilizumab product [Actemra IV or SC, biosimilar]. ☐ Yes ☐ No

Will the patient be starting on Orencia IV concurrently with methotrexate (MTX), sulfasalazine, or leflunomide? ☐ Yes ☐ No

Does the patient have an absolute contraindication to methotrexate, sulfasalazine, or leflunomide? Please Note: Examples of absolute contraindications to methotrexate include pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias. ☐ Yes ☐ No

Does the patient have aggressive disease, as determined by the prescriber? ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

Has the patient tried ANY of the following? Check ALL that apply. Please Note: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes, prescription claims records, and/or prescription receipts.

☐ an adalimumab product (Examples of adalimumab products include Humira, Abrilada, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, adalimumab-aaty, adalimumab-ryvk, Simlandi, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry. A trial of multiple adalimumab products counts as ONE product.)
☐ Cimzia
☐ Enbrel
☐ an infliximab product (Remicade, biosimilars)
☐ Kevzara
☐ Orencia SC
☐ Rinvoq/Rinvoq LQ (A trial of either or both Rinvoq products (Rinvoq and Rinvoq LQ) collectively counts as ONE product.)
☐ Simponi Aria
☐ tocilizumab subcutaneous product (Actemra subcutaneous, biosimilar) (Examples of tocilizumab subcutaneous products include Actemra subcutaneous and Tyenne subcutaneous. A trial of multiple tocilizumab products counts as ONE product.)
☐ tocilizumab intravenous product (Actemra intravenous, biosimilar). A trial of multiple tocilizumab products counts as ONE product.
☐ Xeljanz (A trial of either or both Xeljanz products (Xeljanz tablets and Xeljanz oral solution) collectively counts as ONE product.)

Does the patient have heart failure, a previously treated lymphoproliferative disorder, a previous serious infection, OR a demyelinating disorder, as determined by the prescriber? ☐ Yes ☐ No

If Psoriatic arthritis:

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug)? Please Note: Examples of standardized measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (for example, C-reactive protein, erythrocyte sedimentation rate). ☐ Yes ☐ No

Compared with baseline (prior to initiating the requested drug), has the patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths? ☐ Yes ☐ No

According to the prescriber, has the patient been established on Orencia IV for at least 90 days? PLEASE NOTE: If the patient has been receiving Orencia (subcutaneous formulation) answer NO to this question. Answer YES only if the patient has been on Orencia IV (intravenous formulation) for at least 90 days. ☐ Yes ☐ No

Has the patient tried ANY of the following? Check ALL that apply. Please Note: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes, prescription claims records, and/or prescription receipts.

☐ an adalimumab product (Examples of adalimumab products include Humira, Abrilada, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, adalimumab-aaty, adalimumab-ryvk, Simlandi, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry. A trial of multiple adalimumab products counts as ONE product.)
☐ Cimzia
☐ Cosentyx
☐ Enbrel
☐ an infliximab product (Remicade, biosimilars)
☐ Otezla
☐ Rinvoq/Rinvoq LQ (A trial of either or both Rinvoq products (Rinvoq and Rinvoq LQ) collectively counts as ONE product.)
☐ Simponi (SC or Aria)
☐ Skyrizi SC
☐ Taltz
☐ Tremfya
☐ an ustekinumab subcutaneous product (Examples of ustekinumab products include Stelara/ustekinumab, Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, and Yesintek. A trial of multiple ustekinumab products counts as ONE product.)
☐ Xeljanz/XR (A trial of either or both Xeljanz products (Xeljanz tablets and Xeljanz oral solution) collectively counts as ONE product.)

Does the patient have heart failure, a previously treated lymphoproliferative disorder, a previous serious infection, OR a demyelinating disorder, as determined by the prescriber? ☐ Yes ☐ No

Per the prescriber, has the patient has been receiving Orencia SC for at least 90 days? ☐ Yes ☐ No

Per the prescriber, has the patient has been receiving Orencia SC via paid claims (for example, patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Orencia SC)? ☐ Yes ☐ No

Is the requested medication prescribed by or in consultation with a rheumatologist or a dermatologist? ☐ Yes ☐ No

If Graft-versus-host disease – prevention:

Is Orencia being used for prevention of acute graft-versus-host disease? ☐ Yes ☐ No

Will the patient also receive a calcineurin inhibitor for prevention of acute graft-versus-host disease? Please Note: Examples of calcineurin inhibitors include cyclosporine and tacrolimus. ☐ Yes ☐ No

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

Will the patient undergo hematopoietic stem cell transplantation from one of the following donors (i or ii): i. Matched unrelated donor; OR ii. 1-allele-mismatched unrelated donor? ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with an oncologist, hematologist, or a physician affiliated with a transplant center? ☐ Yes ☐ No

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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