



**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Orencia (abatacept)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: <http://pithelp.appl.kp.org/MAS/formulary.html>**

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Prescriber Information**

Is the prescriber a rheumatologist?  No  Yes

If consulted with a specialist, specialist name and specialty: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ NPI: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

Prescriber Phone #: \_\_\_\_\_ Prescriber Fax #: \_\_\_\_\_

Please check the boxes that apply:

Initial Request  Continuation of Therapy Request

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

Drug 2: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

## 5– Diagnosis/Clinical Criteria

### Initial Therapy:

1. Does the member have diagnosis of rheumatoid arthritis? **AND**  
 No  Yes
  2. Does the member have intolerance, contraindication to, or failed treatment with at least a 6-week trial of one of the following:
    - Subcutaneous methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine, AND
    - Xeljanz (tofacitinib), AND
    - At least 1 TNF inhibitor (e.g., Humira, Enbrel, Inflectra) No  Yes
- OR**
3. Does the member have diagnosis of juvenile idiopathic arthritis or psoriatic arthritis? **AND**  
 No  Yes
  4. Does the member have intolerance, contraindication to, or failed treatment with at least a 3-month trial of at least 1 TNF inhibitor (e.g., Humira, Enbrel, Inflectra)  
 No  Yes
- AND**
5. The member must not be receiving Orencia in combination with any of the following:
    - a. Biologic DMARD (e.g., Enbrel, Humira, Cimzia, Simponi)
    - b. Janus kinase inhibitor (e.g., Xeljanz, Olumiant) No  Yes

### Continuation of Therapy:

1. Does the member document a clinically significant benefit from medication? **AND**  
 No  Yes
2. Has a specialist follow-up occurred in the last 12 months?  
 No  Yes

## 7 – Prescriber Sign-Off

**Additional Information – Please provide any additional information that should be taken into consideration:** \_\_\_\_\_

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

**Prescriber Signature:**

**Date:**

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