Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Orencia (abatacept) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 months

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]. If you have any questions or concerns, please call 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 – Provider Information

Provider Name: ______________________________ Specialty: ____________________ Provider NPI: _________________

Provider Address: ____

Provider Phone #: _________________________Provider 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

1. Does the member have diagnosis of one of the following? **AND**
   □ Rheumatoid Arthritis (RA)

   □ Juvenile Idiopathic Arthritis (JIA)

   □ Other: ___________________

2. Was there therapeutic failure on oral methotrexate? **AND**
   □ No □ Yes

3. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira) **AND**
   □ No □ Yes

4. If this is being used for Rheumatoid arthritis (RA):
   a. Did the patient try and fail or have a contraindication, or adverse reaction to methotrexate and at least one other DMARD (sulfasalazine, hydroxychloroquine, minocycline)?
      □ No □ Yes

6 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

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

Provider Signature:	**Date:**

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