



STANDARD COMMERCIAL DRUG FORMULARY  
PRIOR AUTHORIZATION GUIDELINES

ABATACEPT - SQ

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
ABATACEPT - SQ	ORENCIA - SQ ORENCIA CLICKJECT - SQ		30289 41656 43389 43397	GPI-14 (6640001000D520) (6640001000E510) (6640001000E515) (6640001000E520)	

**NOTE: For requests for the IV dosage form of Orencia, please see the Orencia IV PA Guideline.**

**GUIDELINES FOR USE**

**INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)**

1. Does the patient have a diagnosis of moderate to severe rheumatoid arthritis (RA) and meet **ALL** of the following criteria?
  - The patient is 18 years of age or older
  - Therapy is prescribed by or given in consultation with a rheumatologist
  - The patient had a previous trial of or contraindication to at least 3 months of treatment with at least **ONE** DMARD (disease-modifying antirheumatic drugs), such as methotrexate dose greater than or equal to 20mg per week or maximally tolerated dose, leflunomide, hydroxychloroquine, or sulfasalazine
  - The patient had a previous trial of or contraindication to any **TWO** of the following preferred immunomodulators: Enbrel, Humira, Rinvoq, Xeljanz (IR/XR) [**NOTE:** pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify]

If yes, **approve for 6 months by GPID or GPI-14 with the following quantity limits:**

- **Orencia 125mg/mL SQ syringes: 4mL (#4 - 125mg/mL syringes) per 28 days.**
- **Orencia 125mg/mL ClickJect - SQ: 4mL (#4 - 125mg/mL auto-injectors) per 28 days.**

**APPROVAL TEXT:** Renewal for moderate to severe rheumatoid arthritis requires that the patient has experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.

If no, continue to #2.

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INITIAL CRITERIA (CONTINUED)

2. Does the patient have a diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis (PJIA) and meet **ALL** of the following criteria?

- The patient is 2 years of age or older
- Therapy is prescribed by or given in consultation with a rheumatologist
- The patient had a previous trial of or contraindication to at least **ONE** DMARD (disease-modifying antirheumatic drugs), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine
- The patient had a previous trial of or contraindication to BOTH of the following preferred immunomodulators: Enbrel **AND** Humira [**NOTE:** pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify]

If yes, **approve for 6 months by GPID or GPI-14 with the following quantity limits:**

- **Orencia 125mg/mL SQ syringes: 4mL (#4 - 125mg/mL syringes) per 28 days.**
- **Orencia 87.5mg/0.7mL SQ syringes: 2.8mL (#4 - 87.5mg/0.7mL syringes) per 28 days.**
- **Orencia 50mg/0.4mL SQ syringes: 1.6mL (#4 - 50mg/0.4mL syringes) per 28 days.**

**APPROVAL TEXT:** Renewal for moderate to severe polyarticular juvenile idiopathic arthritis requires that the patient has experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.

If no, continue to #3.

3. Does the patient have a diagnosis of psoriatic arthritis (PsA) and meet **ALL** of the following criteria?

- The patient is 18 years of age or older
- Therapy is prescribed by or given in consultation with a rheumatologist or dermatologist
- The patient had a previous trial of or contraindication to at least **ONE** DMARD (disease-modifying antirheumatic drugs), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine
- The patient had a previous trial of or contraindication to any **TWO** of the following preferred immunomodulators: Cosentyx, Enbrel, Humira, Stelara, Xeljanz (IR/XR), Otezla [**NOTE:** pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify]

If yes, **approve for 6 months by GPID or GPI-14 with the following quantity limits:**

- **Orencia 125mg/mL SQ syringes: 4mL (#4 - 125mg/mL syringes) per 28 days.**
- **Orencia 125mg/mL ClickJect - SQ: 4mL (#4 - 125mg/mL auto-injectors) per 28 days.**

**APPROVAL TEXT:** Renewal for psoriatic arthritis requires that the patient has experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.

If no, do not approve.

**DENIAL TEXT:** See the initial denial text at the end of the guideline.

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INITIAL CRITERIA (CONTINUED)

**INITIAL DENIAL TEXT: \*Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.**

Our guideline named **ABATACEPT - SQ (Orencia - SQ)** requires the following rule(s) be met for approval:

A. You have **ONE** of the following diagnoses:

1. Moderate to severe rheumatoid arthritis (RA: inflammation and stiffness in joints)
2. Moderate to severe polyarticular juvenile idiopathic arthritis (PJIA: swelling and stiffness in joints in children)
3. Psoriatic arthritis (PsA: joint pain and swelling with red scaly skin patches)

**B. If you have moderate to severe rheumatoid arthritis (RA), approval also requires:**

1. You are 18 years of age or older
2. The medication is prescribed by or given in consultation with a rheumatologist (a doctor who specializes in conditions that affects the muscles and skeletal system, especially the joints)
3. You have previously tried at least 3 months of treatment with at least **ONE** DMARD (disease-modifying antirheumatic drugs), unless there is a medical reason why you cannot (contraindication), such as methotrexate dose greater than or equal to 20mg per week or maximally tolerated dose, leflunomide, hydroxychloroquine, or sulfasalazine
4. You have previously tried any **TWO** of the following preferred immunomodulators (class of drugs), unless there is a medical reason why you cannot (contraindication): Enbrel, Humira, Rinvoq, Xeljanz (immediate release/extended release)

**C. If you have moderate to severe polyarticular juvenile idiopathic arthritis (PJIA), approval also requires:**

1. You are 2 years of age or older
2. The medication is prescribed by or given in consultation with a rheumatologist (a doctor who specializes in conditions that affects the muscles and skeletal system, especially the joints)
3. You have previously tried at least **ONE** DMARD (disease-modifying antirheumatic drugs), unless there is a medical reason why you cannot (contraindication), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine
4. You have previously tried **BOTH** of the following preferred immunomodulators (class of drugs), unless there is a medical reason why you cannot (contraindication): Enbrel **AND** Humira

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INITIAL CRITERIA (CONTINUED)

**D. If you have psoriatic arthritis (PsA), approval also requires:**

1. You are 18 years of age or older
2. The medication is prescribed by or given in consultation with a rheumatologist (a doctor who specializes in conditions that affects the muscles and skeletal system, especially the joints) or dermatologist (skin doctor)
3. You have previously tried at least ONE DMARD (disease-modifying antirheumatic drugs), unless there is a medical reason why you cannot (contraindication), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine
4. You have previously tried any **TWO** of the following preferred immunomodulators (class of drugs), unless there is a medical reason why you cannot (contraindication): Cosentyx, Enbrel, Humira, Stelara, Xeljanz (immediate/extended release), Otezla

**NOTE:** The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RENEWAL CRITERIA

1. Does the patient have a diagnosis of moderate to severe rheumatoid arthritis (RA) or psoriatic arthritis (PsA) **AND** meet the following criterion?
  - The patient has experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy

If yes, **approve for 12 months by GPID or GPI-14 with the following quantity limits:**

- **Orencia 125mg/mL SQ syringes: 4mL (#4 - 125mg/mL syringes) per 28 days.**
- **Orencia 125mg/mL ClickJect - SQ: 4mL (#4 - 125mg/mL auto-injectors) per 28 days.**

If no, continue to #2.

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RENEWAL CRITERIA (CONTINUED)

2. Does the patient have a diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis (PJIA) **AND** meet the following criterion?
- The patient has experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy

If yes, **approve for 12 months by GPID or GPI-14 with the following quantity limits:**

- Orencia 125mg/mL SQ syringes: 4mL (#4 - 125mg/mL syringes) per 28 days.
- Orencia 87.5mg/0.7mL SQ syringes: 2.8mL (#4 - 87.5mg/0.7mL syringes) per 28 days.
- Orencia 50mg/0.4mL SQ syringes: 1.6mL (#4 - 50mg/0.4mL syringes) per 28 days.

If no, do not approve.

**RENEWAL DENIAL TEXT: \*Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.**

Our guideline named **ABATACEPT - SQ (Orencia - SQ)** requires the following rule(s) be met for renewal:

- A. You have ONE of the following diagnoses:
- Moderate to severe rheumatoid arthritis (RA: inflammation and stiffness in joints)
  - Moderate to severe polyarticular juvenile idiopathic arthritis (PJIA: swelling and stiffness in joints in children)
  - Psoriatic arthritis (PsA: joint pain and swelling with red scaly skin patches)
- B. You have experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy

Your doctor told us **[INSERT PT SPECIFIC INFO PROVIDED]**. We do not have information showing you **[INSERT UNMET CRITERIA]**. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

**RATIONALE**

For further information, please refer to the Prescribing Information and/or Drug Monograph for Orencia SQ.

**REFERENCES**

- Orencia [Prescribing Information]. Princeton, NJ: Bristol-Myers Squibb Company; June 2017.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A

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