Orencia® SC (abatacept SC)

Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW)
FAX TO: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:
This form is to be used by participating providers to obtain coverage for the drug listed above which requires *prior authorization*. Please complete this form and fax it to *Med**Impact*** Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact Med***Impact*'s** Customer Service at (800) 788-2949.

Member/Provider Information:

MDwise Member's Name:	**Provider's Name:**
MDwise Member's ID #:	**Provider's Specialty:**
MDwise Member's DOB (mm-dd-yy):	**Provider's DEA #:** | **Provider's NPI #:**
Pharmacy used by MDwise Member:	**Provider's Telephone Number/Contact Name (xxx-xxx-xxxx):**
Pharmacy Telephone Number (xxx-xxx-xxxx):	**Provider's Fax Number (xxx-xxx-xxxx):**

Clinical Information:

Requested Drug: ☐ **Orencia® SC** **NOTE: The IV dosage form of Orencia® is not a covered pharmacy benefit.**	
Dose and Quantity Requested:	
Date Requested:	**Length of Treatment** (please be specific)**:**

Documentation of Medical Necessity (please check all that apply):

1. Does the patient have a diagnosis of **moderate to severe** rheumatoid arthritis? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient achieved or maintained ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

Has the patient tried at least **ONE** of the following DMARDs?

methotrexate	☐ Yes	☐ No	**If yes**, describe the response/reaction to each medication below:
leflunomide	☐ Yes	☐ No	_____
hydroxychloroquine	☐ Yes	☐ No	_____
sulfasalazine	☐ Yes	☐ No	_____

2. Does the patient have a diagnosis of **moderate to severe** polyarticular juvenile idiopathic arthritis? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient achieved or maintained ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

Has the patient tried at least **ONE** of the following DMARDs?

methotrexate	☐ Yes	☐ No	**If yes**, describe the response/reaction to each medication below:
leflunomide	☐ Yes	☐ No	_____
hydroxychloroquine	☐ Yes	☐ No	_____
sulfasalazine	☐ Yes	☐ No	_____

3. Does the patient have a diagnosis of **psoriatic arthritis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e. is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained ≥20% improvement in tender or swollen joint count while on this medication? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist or a dermatologist? ☐ Yes ☐ No

AND

Has the patient tried at least **ONE** of the following DMARDs?

methotrexate	☐ Yes	☐ No	**If yes**, describe the response/reaction to that medication below:
leflunomide	☐ Yes	☐ No	_____
hydroxychloroquine	☐ Yes	☐ No	_____
sulfasalazine	☐ Yes	☐ No	_____

4. Please attach additional information which may indicate ***why this specific medication*** is being requested for this patient.