SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Orencia® SQ (abatacept) **(Pharmacy)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

DIAGNOSIS	Recommended Dose
❑ **Moderate to severe Active Rheumatoid Arthritis (RA)** ❑ **Psoriatic Arthritis (PsA)**	**SUBCUTANEOUS** • 125 mg once a week (4 syringe/28 days) Pediatric dosing: • **Weighing 10 kg to less than 25 kg:** 50 mg once a week (1 syringe/28 days) • **Weighing 25 kg to less than 50 kg**: 87.5 mg once a week (1 syringe/28 days) • **Weighing 50 kg or greater:** 125 mg once a week (4 syringes/28 days)

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DIAGNOSIS	Recommended Dose
❑ **Juvenile Idiopathic Arthritis (pJIA) in members 2 years and older**	**SUBCUTANEOUS** • **Weighing greater 50 kg**: 125 mg once a week (4 syringes/28 days) • **Weighing 25 kg to less than 50 kg:** 87.5 mg (Four syringes of 87.5mg/28days) once a week • **Weighing 10kg to 25 kg**: 50 mg once a week (Four syringes of 50 mg/28 days)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Diagnosis - Check applicable diagnosis below

❑ Moderate to severe Active Rheumatoid Arthritis (RA)

- ❑ Member is 18 years of age or older
- ❑ Member has been diagnosed with moderate to severe rheumatoid arthritis
- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate
- ❑ Trial and failure of at least **ONE (1)** other **DMARD therapy** including, but not limited to: **(check each tried)**

❑ auranofin	❑ sulfasalazine
❑ azathioprine	❑ leflunomide
❑ hydroxychloroquine	❑ other: _____

- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Polyarticular Juvenile Idiopathic Arthritis (pJIA)

- ❑ Member is 2 years of age or older
- ❑ Member has been diagnosed with moderate to severe active Polyarticular Juvenile Idiopathic Arthritis (pJIA)
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ Humira®	❑ Enbrel®

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❑ Active Psoriatic Arthritis (PsA)

- ❑ Member is 2 years of age and older
- ❑ Member has been diagnosed with moderate to severe active Psoriatic Arthritis (PsA)
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

REVISED/UPDATED/REFORMATTED: ~~8/1/2017; 12/20/2017; 6/4/2018; 8/28/2018; 10/8/2018; 12/9/2018; 4/6/2019; 7/19/2021; 1/6/2022; 6/29/2022; 7/13/2022; 6/20/2023, 11/10/2023; 6/07/2024,~~ **10/17/2025**