SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Orencia® (abatacept) **(J-0129) (IV INFUSION ONLY) (Medical)**

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

DIAGNOSIS	Recommended Quantity
❑ **Moderately to severely active Rheumatoid Arthritis (RA)**	**INTRAVENOUS** • Weight <60kg: Two vials per 28 days • Weight 60-100kg: Three vials per 28 days • Weight >100kg: Four vials per 28 days
❑ **Psoriatic arthritis (PsA)**	**INTRAVENOUS** • Weight <60kg: Six 250mg vials initial 28 days Two vials per 28 days after induction • Weight 60-100kg: Nine vials in initial 28 days Three vials per 28 days after induction • Weight >100kg: Twelve vials initial 28 days Four vials per 28 days after induction

(Continued on next page)

DIAGNOSIS	Recommended Quantity
❑ **Juvenile Idiopathic Arthritis (JIA) in members 2 years and older**	**INTRAVENOUS** • ≥ 6 y/o (subcutaneous formulation indicated for 2 years and older) • Weight <75kg: 10mg/kg every 28 days (3 vial) • Weight >75kg: Follow adult Rheumatoid Arthritis dosing above (not to exceed max dose 1000mg)
❑ **Prophylaxis of acute graft versus host disease (aGVHD)**	**INTRAVENOUS** • Patients 2 to less than 6 years old, administer a 15 mg/kg dose as a 60-minute infusion on the day before transplantation, followed by a 12 mg/kg dose as a 60-minute infusion on Day 5, 14, and 28 after transplant • Patients 6 years and older, 10 mg/kg dose (maximum dose 1,000 mg) as a 60-minute infusion day before transplantation, followed by a dose on Day 5, 14, and 28 after transplant

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINCIAL 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: Moderate to severe Active Rheumatoid Arthritis (RA)**

❑ Prescriber is a **Rheumatologist**

AND

❑ Member has been diagnosed with **moderate to severe rheumatoid arthritis**

AND

❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

❑ 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: _____

AND

(Continued on next page)

- ❑ Member has tried and failed **TWO (2)** of the following biologics:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Juvenile Idiopathic Arthritis (JIA)

- ❑ Prescriber is a **Rheumatologist**

AND

- ❑ Member has been diagnosed with **moderate to severe active Juvenile Idiopathic Arthritis (JIA)**

AND

- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

- ❑ 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: _____

AND

- ❑ Patient has tried and failed **TWO (2)** of the biologics below:

❑ Humira®	❑ Enbrel®

❑ Diagnosis: Active Psoriatic Arthritis (PsA)

- ❑ Prescriber is a **Rheumatologist**

AND

- ❑ Member has been diagnosed with **moderate to severe active Psoriatic Arthritis (PsA)**

AND

- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

(Continued on next page)

- ❑ 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: _____

AND

- ❑ Member has tried and failed **TWO (2)** of the following biologics:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Diagnosis: Prophylaxis of acute graft versus host disease (aGVHD)

- ❑ Member has a diagnosis of prophylaxis of acute graft versus host disease (aGVHD)

AND

- ❑ Member is 2 years of age and older undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor

AND

- ❑ The medication is used in combination with a calcineurin inhibitor and methotrexate

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

- ❑ **Location/site of drug administration**: _____

  NPI or DEA # of administering location: _____

OR

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

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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.