Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

ORENCIA® (ABATACEPT)

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. What is the patient's diagnosis?
- ☐ Adult Rheumatoid Arthritis (RA)
- ☐ Juvenile Idiopathic Arthritis (JIA)
- ☐ Adult Psoriatic Arthritis (PSA)

Q2. Is the prescriber a rheumatologist or in consultation with a rheumatologist?
☐ Yes ☐ No

Q3. Has the patient failed or had an inadequate response to the trial of at least one or more DMARD OR is intolerant to DMARDs [e.g., Imuran (azathioprine), Ridaura (oral gold), Plaquenil (hydroxychloroquine), Cuprimine (D-penicillamine), Azulfidine (sulfasalazine), methotrexate and NSAIDs]?
☐ Yes ☐ No

Q4. Has the patient had a trial and inadequate response or is intolerant to one or more DMARD or is intolerant to DMARDs [e.g., NSAIDs, Azulfudine (sulfasalazine), methotrexate, Imuran (azathioprine), cyclosporine, prednisone?
☐ Yes ☐ No

Q5. Has the patient had a trial and inadequate response or is intolerant to Enbrel and/or Humira? Or Is the patient being treated with Orencia Intravenously and preferring to switch to subcutaneous Orencia?
☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Has patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q7. If latent infection is diagnosed, has the patient received appropriate prophylaxis in accordance with the CDC and prevention guidelines should be instituted?

☐ Yes ☐ No

Q8. Is the patient being treated for any other active infection?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months

Q10. Additional Information:

Prescriber Signature

Date

Updated 2018