



**PRIOR AUTHORIZATION REQUEST FORM**

EOC ID:

**ORENCIA® (ABATACEPT)**

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

HEALTH PARTNERS 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 print clearly.**

<b>Patient Name:</b>  Member Number: Date of Birth: Group Number: Address: City, State, Zip:	<b>Physician Name:</b>  Fax: <span style="float:right">Phone:</span> Office Contact: NPI: <span style="float:right">State Lic. Id:</span> Address: City, State, Zip:
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Drug Name: Expedited/Urgent

Directions:

<b>Please answer the following questions and sign below:</b>
Q1. What is the prescriber's specialty? <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other
Q2. If Other, Please specify:
Q3. What is the patient's diagnosis? <input type="checkbox"/> Active Rheumatoid Arthritis(RA) <input type="checkbox"/> Active Polyarticular Juvenile Idiopathic Arthritis <input type="checkbox"/> Other
Q4. If OTHER, please specify:
Q5. For polyartricular juvenile idiopathic arthritis: Is the patient equal to or greater than 6 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. For Moderately to severely active polyarticular-course juvenile rheumatoid arthritis (greater than or equal to 6 years old): Has the patient tried and failed either Enbrel or Humira? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q7. Has the patient tried and failed or intolerant to one of the DMARDs or one of the TNF-Blocking Agents (Enbrel, Humira, Remicade)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. If the patient was receiving a Tumor Necrosis Factor (TNF) blocking agent (e.g., Enbrel®, Humira®, Remicade®) or an anticytokine (anakinra (Kineret®)), will it be discontinued prior to ORENCIA® therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

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**Physician Signature**

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**Date**