Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Orencia
(abatacept / maltose)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Orencia 50mg/0.4ml syringe ☐ Orencia 87.5mg/0.7ml syringe
☐ Orencia 125mg/ml syringe ☐ Orencia ClickJect 125mg/ml auto-injector ☐ Orencia 250mg vial

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:
What is your patient's current weight?
Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of **Orencia**, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

(if continued therapy) Has your patient had a good response to therapy with this drug (such as improvement or remission)?
☐ Yes ☐ No

(if no) Please provide clinical support for the continued use of **Orencia**:

Please provide the dates your patient has received **Orencia**:

Besides the drug being requested, other biological drugs include Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Stelara, Taltz, Tremfya, Tysabri, and Xeljanz/Xeljanz XR. Which of the following best describes your patient's situation?
☐ The patient is NOT taking any other biological at this time, nor will they in the future. The requested drug is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biological, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biological.
☐ other/unknown
(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another biologic to treat your patient's diagnosis.

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:

Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use (please specify):

☐ Graft-versus-Host Disease (GvHD) ☐ polyarticular juvenile idiopathic arthritis (pJIA) ☐ psoriatic arthritis (PsA)
☐ rheumatoid arthritis (RA)
☐ other (please specify):

Clinical Information:

(if GvHD) Will the patient also receive a calcineurin inhibitor (for example, cyclosporine and tacrolimus) for prevention of acute graft-versus-host disease? ☐ Yes ☐ No or Unknown

(if GvHD) Will the patient also receive methotrexate for prevention of acute graft-versus-host disease? ☐ Yes ☐ No or Unknown

(if GvHD) Will the patient undergo hematopoietic stem cell transplantation from a matched unrelated donor? ☐ Yes ☐ No or Unknown

(if no) Will the patient undergo hematopoietic stem cell transplantation from a 1-allele- mismatched unrelated donor? ☐ Yes ☐ No or Unknown

(if GvHD) Is this drug being prescribed by, or in consultation with, an oncologist, hematologist, or a physician affiliated with a transplant center? ☐ Yes ☐ No or Unknown

(if PJIA) Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in Polyarticular Juvenile Idiopathic Arthritis (PJIA)? ☐ Yes ☐ No

(if PJIA) The covered alternatives are: Actemra SQ, Enbrel, Humira, Orencia SQ. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

(if pJIA) Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?

☐ The patient tried 2 (or more) of the alternatives, but these drugs didn't work well enough
☐ The patient is able to try at least one of these alternatives, but has not done so yet
☐ Other

if pJIA) For each alternative that your patient didn't try, please provide details why they can't try that alternative [including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has; inability to administer the covered alternative and requires this dosage formulation].

(if PsA) Is this drug being prescribed by, or in consultation with, a rheumatologist, dermatologist or a prescriber who specializes in psoriatic arthritis? ☐ Yes ☐ No

(if PsA) The covered alternatives are: Cimzia, Cosentyx, Enbrel, Humira, Orencia SQ, Simponi SQ, Skyrizi, Stelara SQ, and Taltz. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

(if PsA) Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?

☐ The patient tried 2 (or more) of the alternatives, but these drugs didn't work well enough
☐ The patient is able to try at least one of these alternatives, but has not done so yet
☐ Other

(if PsA) For each alternative that your patient didn't try, please provide details why they can't try that alternative [including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has; inability to administer the covered alternative and requires this dosage formulation].

(if RA) Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in rheumatoid arthritis?
☐ Yes ☐ No

(if RA) The covered alternatives are: Actemra SQ, Cimzia, Enbrel, Humira, Kevzara, Kineret, Orencia SQ, Simponi SQ. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

(if RA) Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?

☐ The patient tried 2 (or more) of the alternatives, but these drugs didn't work well enough
☐ The patient is able to try at least one of these alternatives, but has not done so yet
☐ Other

(if RA) For each alternative that your patient didn't try, please provide details why they can't try that alternative [including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has; inability to administer the covered alternative and requires this dosage formulation].

(if PsA or RA) Has your patient already tried any other biologic or tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) such as Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Tysabri, Xeljanz/Xeljanz XR, and Zeposia?
☐ Yes ☐ No or Unknown

(PsA or RA, if no) The covered alternative is one disease-modifying anti-rheumatic drug (DMARD) (for example: methotrexate, leflunomide, sulfasalazine). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(PsA or RA, if no) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?

☐ The patient tried one of the alternatives, but it didn't work well enough.
☐ The patient is able to try at least one of these alternatives, but has not done so yet
☐ The patient tried at least one covered alternative, but had a significant intolerance to it
☐ The patient can't try at least one of these alternatives because of one of the following: contraindication according to the FDA label; a warning per the prescribing information (labeling); a disease characteristic or clinical factor the patient has
☐ Other

Additional pertinent information: *Please include any alternatives tried, with drug name, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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