

Health New England
Medication Request Form (MRF)/Prescription Request
Orencia® (abatacept)

- | | |
|--------------------------|-------------------------------------------------------|
| <input type="checkbox"/> | Preferred drug accepted. New verbal order authorized. |
| <input type="checkbox"/> | Preferred drug rejected by physician. |

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

- Prior Authorization Only**
- Prior Authorization and Drug Delivery Request**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Orencia. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

J-Code: J3590. 1 Unit = 250mg

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)		Physician Information (all required)	
Patient Name:		Physician Name :	
		Specialty:	
Patient Cell Phone #: () -		NPI #:	
Patient HNE ID#:		HNE Provider #:	
Patient Date of Birth:		DEA #:	
Allergies:		Telephone #: () -	
Diagnosis:		Fax #: () -	

Drug Information

Preferred Drug: Enbrel Humira

Requested Drug/Strength/Form: **Orencia®** usual dosing is: 500mg if weight is less than 60kg
750mg if weight is between 61-100kg
1000mg if weight is greater than 100kg

Weight (required):

Dose, Directions, and length of treatment (please be specific):

Quantity (per month):

Refills:

Physician Signature:

Date:

Indication:

- Moderate to severe rheumatoid arthritis
 Pediatric patient 6 years of age or older with moderately to severely active polyarticular juvenile idiopathic arthritis

Documentation of Medical Necessity (check all that apply):

- Therapy is being initiated or recommended by a rheumatologist
 Patient is intolerant to or failed therapy with one DMARD (methotrexate, sulfasalazine, hydroxychloroquine, aurothioglucose, gold, azathioprine)
 Patient is intolerant to or has failed Enbrel (etanercept) or Humira (adalimumab)
 Pregnancy has been excluded or if female is of child-bearing age appropriate contraception is being utilized.
 Active infections have been excluded (including but not limited to localized infections, histoplasmosis, cytomegalovirus, tuberculosis, Hepatitis B and HIV)
 The patient will NOT receive another tumor necrosis factor antagonist such as Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab) or Kineret (anakinra) or Arava (leflunomide)
 For continuation of therapy, patient has demonstrated a clinical response to treatment
 Other pertinent history: _____