# Orencia

## HMSA Medicare Advantage - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

**Patient's Name:** _____ **Date**: _____
**Patient's ID:** _____ **Patient's Date of Birth:** _____
**Patient's Phone Number:** _____
**Physician's Name:** _____
**Specialty:** _____ **NPI#:** _____
**Physician Office Telephone:** _____ **Physician Office Fax:** _____

***Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.***

**Additional Demographic Information:**

*Patient Weight:* _____*kg*

*Patient Height:* _____*ft* _____*inches*

***Indicate where the drug is being dispensed:***

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

***Indicate where the drug is being administered:***

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

**Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512**

**Criteria Questions:**

1. Is the patient currently receiving treatment with Orencia?
❒ Yes, *Continue to #2*
❒ No, *Continue to #4*

2. What is the patient's diagnosis?
❒ Rheumatoid arthritis, *Continue to #3*
❒ Articular juvenile idiopathic arthritis, *Continue to #3*
❒ Psoriatic arthritis, *Continue to #3*
❒ Prophylaxis of acute graft versus host disease, *Continue to #5*
❒ Giant cell arteritis, *Continue to #3*
❒ Chronic graft versus host disease, *Continue to #3*
❒ Immune checkpoint inhibitor-related toxicity, *Continue to #9*
❒ Other, *No Further Questions*

3. Is the patient receiving benefit from therapy? ***Chart notes or medical record documentation supporting benefit from therapy must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. What is the patient's diagnosis?
❒ Active rheumatoid arthritis, *No Further Questions*
❒ Active articular juvenile idiopathic arthritis, *No Further Questions*
❒ Active psoriatic arthritis, *No Further Questions*
❒ Prophylaxis of acute graft versus host disease, *Continue to #5*
❒ Giant cell arteritis, *No Further Questions*
❒ Chronic graft versus host disease, *Continue to #7*
❒ Immune checkpoint inhibitor-related toxicity, *Continue to #9*
❒ Other, *No Further Questions*

5. Is the patient undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated-donor?
❒ Yes, *Continue to #6*
❒ No, *Continue to #6*

6. Will the requested medication be used in combination with a calcineurin inhibitor (e.g., cyclosporine, tacrolimus) and methotrexate?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. Has the patient experienced an inadequate response to systemic corticosteroids? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy, must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *Continue to #8*

8. Does the patient have an intolerance or contraindication to corticosteroids***? If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy, must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

9. Does the patient have myocarditis?
❒ Yes, *Continue to #10*
❒ No, *Continue to #10*

10. Has the patient had an inadequate response to systemic corticosteroids? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy, must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *Continue to #11*

11. Does the patient have an intolerance or contraindication to corticosteroids? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy, must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *Continue to #12*

12. Does the patient have concomitant myositis and the requested medication will be used in combination with ruxolitinib?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X_____**
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**