

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
ORENCIA (abatacept)

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN A LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Diagnosis of moderate to severe rheumatoid arthritis for patient age 18 and older **OR**
- Diagnosis of Juvenile Idiopathic Arthritis for patients age 6 months and older.
- History of treatment failure, incomplete response or intolerance to Methotrexate or one other DMARD or second line drug (azathioprine, sulfasalazine, leflunomide, penicillamine, hydroxychloroquine, etc.).
- The number of swollen joints, must be 6 or more (**WRITE SPECIFIC NUMBER IN NOTES OR LETTER**)
- The number of tender joints must be 9 or more (**WRITE SPECIFIC NUMBER IN NOTES OR LETTER**)
- Negative TB skin test or history of treatment for latent TB infection.
- Patient is absent of active bacterial or viral infection, malignancy, or immunosuppressive condition
- Rheumatology consult within the last 60 days

NOTES:

Available as a Non-Traditional Medicaid Benefit.

INFORMATION:

Infusion to be administered in clinic setting only. Patient's with HMO's (except IHC) will have to make arrangements with their HMO coverage. Provider will bill with J code J0129 and a PA number. New dispensing syringe may be obtained through pharmacy.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance.

12/22/2011

<http://health.utah.gov/medicaid/pharmacy>