

**Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form**



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	Name
ID Number	Specialty
D.O.B. MM/DD/YYYY <input type="checkbox"/> Male <input type="checkbox"/> Female	Address
Diagnosis	City /State/Zip
Drug Name Orencia SC	Phone: Fax:
Dose and Quantity	NPI
Directions	Contact Person
Date of Service(s)	Contact Person Phone / Ext.

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ ft _____ inches

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?
 Yes No *If No, a prior authorization is not required through this process.*

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

If primary, continue with questionset.

If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Site of Care:

A. At what location will the member be receiving the requested medication?

Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.

Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting.

Other. Please specify. _____

NOTE: Form must be completed in its **entirety** for processing

Criteria Questions:

1. Is this **INITIATION** of Orencia therapy? *Please select answer below:*
 - NO** – this is a PA renewal for **CONTINUATION** of therapy, please answer questions on continuation section.
 - YES** – this is **INITIATION** of therapy, please answer the following questions:
2. What is the patient's diagnosis?
 - Juvenile Rheumatoid Arthritis (JRA) / Polyarticular Juvenile Idiopathic Arthritis (pJIA)
 - a. Is the patient's arthritis active? Yes No
 - b. What is the patient's weight? *Please select answer below:*
 - Less than 10kg (22 lbs)**
 - 10kg (22lbs) to less than 25kg (55lbs)**
Does the prescriber agree to administer the medication within the FDA labeled dose of 50mg every week? Yes No
 - 25kg (55lbs) to less than 50kg (110lbs)**
Does the prescriber agree to administer the medication within the FDA labeled dose of 87.5mg every week? Yes No
 - Greater than 50kg (110 lbs)**
Does the prescriber agree to administer the medication within the FDA labeled dose of 125mg every week? Yes No
 - Psoriatic Arthritis (PsA)
 - a. Does the patient have active psoriatic arthritis? Yes No
 - b. Does the prescriber agree to administer Orencia within the FDA labeled dose of 125mg every week? Yes No
 - Rheumatoid Arthritis (RA)
 - a. Does the patient have moderate to severely active rheumatoid arthritis? Yes No
 - b. Does the prescriber agree to administer Orencia within the FDA labeled dose of 125mg every week? Yes No
 - Other diagnosis (*please specify*): _____
3. Does the patient have a contraindication to at least one conventional disease-modifying antirheumatic drug (DMARD)? Yes No*
**If NO*, has the patient experienced an inadequate treatment response or intolerance to at least a 3-month trial of at least one conventional DMARD? Yes No
4. Has the patient had a TB test to rule out tuberculosis (TB)? Yes* No
**If YES*, what was the result of the patient's TB test? Negative Positive*
**If POSITIVE*, is the patient receiving treatment or has already completed treatment for TB by standard medical practice? Yes No
5. Is the patient at risk for a Hepatitis B Virus (HBV) infection? Yes* No
**If YES*, has the HBV infection been ruled out or has the patient already started treatment for the HBV infection? Yes No
6. Does the patient have any active infections including TB and HBV? Yes No
7. Will the patient be given live vaccines while on Orencia therapy? Yes No
8. Will Orencia be given in combination with any other biologic DMARD* or targeted synthetic DMARD? *Please select answer below:*
 Yes (*please specify*): _____ No

**DMARDs include: Actemra, Cimzia, Costentyx, Enbrel, Entyvio, Humira, Infliximab, Kevzara, Kineret, Otezla, Rituxan, Siliq, Simponi, Stelara, Taltz and Xeljanz*

**CONTINUATION OF ORENCIA SUBCUTANEOUS THERAPY
(PA RENEWAL)**

NOTE: Form must be completed in its **entirety** for processing

1. Is this a PA renewal for **CONTINUATION** of Orencia therapy? *Please select answer below:*
 - NO** – this is **INITIATION** of therapy, please answer questions on **initiation section**.
 - YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

2. What is the patient's diagnosis?
- Juvenile Rheumatoid Arthritis (JRA) / Polyarticular Juvenile Idiopathic Arthritis (pJIA)
 - a. What is the patient's weight? *Please select answer below:*
 - Less than 10kg (22 lbs)**
 - 10kg (22lbs) to less than 25kg (55lbs)**
Does the prescriber agree to administer the medication within the FDA labeled dose of 50mg every week? Yes No
 - 25kg (55lbs) to less than 50kg (110lbs)**
Does the prescriber agree to administer the medication within the FDA labeled dose of 87.5mg every week? Yes No
 - Greater than 50kg (110 lbs)**
Does the prescriber agree to administer the medication within the FDA labeled dose of 125mg every week? Yes No
 - Psoriatic Arthritis (PsA)
 - a. Does the prescriber agree to administer Orencia within the FDA labeled dose of 125mg every week? Yes No
 - Rheumatoid Arthritis (RA)
 - a. Does the prescriber agree to administer Orencia within the FDA labeled dose of 125mg every week? Yes No
 - Other diagnosis (*please specify*): _____
3. Has the patient's condition improved or stabilized with Orencia? Yes No
4. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? Yes No
5. Will the patient be given live vaccines while on Orencia? Yes No
6. Will Orencia be used in combination with any other biologic DMARD* or targeted synthetic DMARD? Yes* No
- *If YES, please specify:* _____
- *DMARDs include: Actemra, Cimzia, Costentyx, Enbrel, Entyvio, Humira, Infliximab, Kevzara, Kineret, Otezla, Rituxan, Siliq, Simponi, Stelara, Taltz and Xeljanz*

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review (required)

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

- Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	Physician Signature	Date
Step 2: Checklist <ul style="list-style-type: none"> <input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Provide chart notes 		<input type="checkbox"/> Attach test results
Step 3: Submit	By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979	By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320

Confidentiality notice: This transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this in error, please notify the sender to arrange for the return of this document.