TRICARE Prior Authorization Request Form for
abatacept subcutaneous **(Orencia SC)**

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HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior Authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete clinical assessment:**

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes Proceed to question **2**	☐ No Proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **5**	☐ No Proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [for example: sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Will the patient be taking the TNF antagonists at the same time as Orencia?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**
7. Is the patient the patient 18 years of age or older?	☐ Yes Proceed to question **8**	☐ No Proceed to question **9**

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8. What is the indication or diagnosis?	☐ Moderate to severe active **rheumatoid arthritis** – Proceed to question **11** ☐ Active **psoriatic arthritis** – Proceed to question **11** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
9. Is the patient the patient 2 to 17 years of age or older?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. What is the indication or diagnosis?	☐ Moderately to severely active **polyarticular juvenile idiopathic arthritis** – Proceed to question **11** ☐ Active **psoriatic arthritis** – Proceed to question **11** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
11. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Will the patient be receiving other targeted immunomodulatory biologics with Orencia including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[26 June 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: