US Family Health Plan
Prior Authorization Request Form for
abatacept subcutaneous **(Orencia SC)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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 **3**	☐ No proceed to question **2**
2. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **6**	☐ No Proceed to question **3**
3. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **6**	☐ No Proceed to question **4**
4. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. Does the patient have a diagnosis of symptomatic congestive heart failure (CHF) and requires a non-TNF (tumor necrosis factor) biologic agent?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a diagnosis of moderate to severe active rheumatoid arthritis?	☐ Yes proceed to question **9**	☐ No proceed to question **7**
7. Does the patient have a diagnosis of psoriatic arthritis?	☐ Yes proceed to question **9**	☐ No proceed to question **8**
8. Does the patient have a diagnosis of juvenile idiopathic arthritis?	☐ Yes proceed to question **10**	☐ No - **STOP** **Coverage not approved**
9. Is the patient the patient 18 years of age or older?	☐ Yes proceed to question **11**	☐ No - **STOP** **Coverage not approved**

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10. Is the patient the patient 2 years of age or older?	☐ Yes proceed to question **11**	☐ No - **STOP** **Coverage not approved**
11. Will the patient be receiving other targeted immunomodulatory biologics with Orencia, including but not limited to the following: Actemra, Cimzia, Enbrel, Humira, Kineret, Otezla, Remicade, Rituxan, Simponi, Stelara, or Xeljanz?	☐ Yes **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

[30 April 2018]