Medical drug benefit
Prior authorization request

WellSense HEALTH PLAN

Orencia
Version20 Effective: 07/10/2023

Phone: 877-417-1839 (NH Medicaid)
Fax: 866-539-7185

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient Information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Requested dosing
Please document the requested dosing:

4. Member's weight in kg

Please document the member's weight in kg:

5. Concurrent use

Will the member be using the requested medication concurrently with a biologic or a targeted synthetic DMARD?

- ☐ Yes
- ☐ No

6. Other conditions

Does the member have any of the following conditions? Please choose any of the following that apply

- ☐ Ankylosing spondylitis
- ☐ Inflammatory bowel disease (i.e. Crohn's disease, ulcerative colitis)
- ☐ Psoriasis
- ☐ None of the above

7. Diagnosis

Please choose the appropriate diagnosis

- ☐ Juvenile Idiopathic Arthritis/Juvenile Rheumatoid Arthritis (proceed to Q8)
- ☐ Psoriatic Arthritis (proceed to Q9)
- ☐ Rheumatoid Arthritis (proceed to Q9)
- ☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request

8. Juvenile idiopathic arthritis/Juvenile rheumatoid arthritis

Please choose **all** of the following that apply: (proceed to Q10)

☐ Member has tried Simponi Aria

☐ Member has heart failure, previously treated lymphoproliferative disorder, or a previous serious infection

☐ Member has been established on Orencia Intravenous or Orencia Subcutaneous for at least 90 days

☐ Other (please specify):

9. Psoriatic arthritis or rheumatoid arthritis

Please choose **all** of the following that apply (proceed to Q11 for rheumatoid arthritis or to Q12 for psoriatic arthritis)

☐ Member has tried Simponi Aria or Cimzia or both

☐ Member has heart failure, previously treated lymphoproliferative disorder, or a previous serious infection

☐ Member has been established on Orencia Intravenous or Orencia Subcutaneous for at least 90 days

☐ Other (please specify):

10. Juvenile idiopathic arthritis/juvenile rheumatoid arthritis

Please choose **one** of the following that apply (proceed to Q12):

☐ Member has tried one other agent for this condition(e.g. methotrexate, sulfasalazine, or leflunomide, and an NSAID)

☐ Member will be starting on therapy concurrently with methotrexate, sulfasalazine, or leflunomide

☐ Member has an aggressive disease

☐ Member has an absolute contraindication to methotrexate, sulfasalazine, or leflunomide (please specify the drug and associated contraindication)

☐ Other (please specify):

11. For rheumatoid arthritis

Please choose **all** of the following that apply (proceed to Q12)

☐ Member has tried one conventional synthetic DMARD for at least 3 months (e.g. methotrexate, leflunomide, hydroxycloroquine, and sulfasalazine)

☐ Other (please specify)

12. Specialty of the Prescriber

Please indicate what specialty the prescriber is (select any that apply):

☐ Dermatologist

☐ Rheumatologist

☐ Other (please indicate what specialty below):

13. Initial or Continuing Therapy

Is the request for initial or continuing therapy?

☐ Initial (Proceed to Q16)

☐ Continuation (Proceed to Q14)

14. Response

Did the member have a response to therapy?

☐ Yes (proceed to Q15)

☐ No

15. Appropriate Response to Therapy

Please choose the appropriate response to therapy

- ☐ Decrease soft tissue swelling in joints or tendon sheaths
- ☐ Improvement in limitation of movement
- ☐ Improved function or activities of daily living
- ☐ Improved laboratory values
- ☐ Less joint pain, tenderness, morning stiffness or fatigue
- ☐ Improvements in C-reactive protein
- ☐ Reduced dosage of corticosteroids
- ☐ Other, please specify:

16. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

- ☐ HCPCS / Qcodes:
- ☐ Number of units:
- ☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.