OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Orencia® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Active psoriatic arthritis (PsA)
❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)
❑ Moderately to severely active rheumatoid arthritis (RA)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of prior Orencia subcutaneous (SC) therapy? ❑ **Yes** ❑ **No**
Is this request for continuation of prior Orencia intravenous (IV) therapy? ❑ **Yes** ❑ **No**
Select if Orencia is prescribed by or in consultation with one of the following specialists:
- ❑ Dermatologist
- ❑ Rheumatologist

Select if the patient has had trial and failure, contraindication, intolerance, or attestation demonstrating a trial may be inappropriate to the following, if applicable for the patient's diagnosis:
- ❑ Cimzia
- ❑ Enbrel
- ❑ Humira
- ❑ Simponi
- ❑ Stelara

Will Orencia be used in combination with a biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]? ❑ **Yes** ❑ **No**

For moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA), also answer the following:

Has the patient had a trial and failure, contraindication, or intolerance to Arava (leflunomide) or Rheumatrex/Trexall (methotrexate)? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to Orencia therapy? ❑ **Yes** ❑ **No**
Will Orencia be used in combination with a biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]? ❑ **Yes** ❑ **No**

Orencia® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Quantity Limit:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.