Fax Referral To: 800-323-2445
Phone: 866-278-6634

Orencia® (abatacept)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: __________ **Needs by Date (Please Specify):** __________

Ship to: ☐ Patient ☐ Office ☐ Other: ____________________

PATIENT INFORMATION	PRESCRIBER INFORMATION
(Complete the following or send patient demographic sheet)	Prescriber's Name:
Patient Name:	State License #: UPIN:
Address:	DEA #: NPI #:
City, State, Zip:	Group or Hospital:
Home Phone:	Address:
Alternate Phone:	City, State Zip:
Last Four of SS #: Primary Language:	Phone: Fax:
Insurance ID:	Contact Person:
Date of Birth: Gender:	Contact Phone:

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card*)

Prescription Card:	Name of Insurer:	ID#:	BIN:	PCN:	Group:
Primary Insurance:	Subscriber:	ID#:	Name of Insurer: **Blue Cross Blue Shield of RI**		Phone:
Secondary Insurance:	Subscriber:	ID#:	Name of Insurer:		Phone:

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): ☐ 714.0 Rheumatoid Arthritis ☐ Other: __________ • Date of Diagnosis: __________

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient Age __________ • Weight __________
- Is this request for initial therapy or continuation of therapy? ☐ Initial ☐ Continuation
- What will be the route of Orencia administration? (For adult RA, prescribers must indicate one route of administration – coverage is provided for either the SC route or the IV route, but not both.) ☐ IV infusion ☐ SC injection
- Patient has been diagnosed with moderate to severe active Rheumatoid Arthritis ☐ Yes ☐ No
  - Patient has failed or had an inadequate response to one or more disease modifying antirheumatic agents (DMARDs): ☐ Yes ☐ No
    - ☐ Auranofin (Ridaura) ☐ Azathioprine (Imuran) ☐ Cyclophosphamide (Cytoxan or Neosar)
    - ☐ Cyclosporine (Neoral or Sandimmune) ☐ Gold sodium thiomalate (Myochrysine) ☐ Hydroxychloroquine (Plaquenil)
    - ☐ Leflunomide (Arava) ☐ Methotrexate ☐ Minocycline (Minocin or Dynacin)
    - ☐ Penicillamine (Cuprimine, Depen) ☐ Sulfasalazine (Azulfidine, Azulfidine EN-tabs)
  - If no, does the patient have a contraindication or intolerance to one or more DMARDs? ☐ Yes ☐ No
  - Patient had an inadequate response to at least 2 TNF blocking agents? ☐ Yes ☐ No
    - ☐ Cimzia (certolizumab pegol) ☐ Enbrel (etanercept) ☐ Humira (adalimumab)
    - ☐ Simponi (golimumab) ☐ Remicade (infliximab)
  - If no, does the patient have a contraindication or intolerance to at least 2 TNF blocking agents? ☐ Yes ☐ No
- Patient has a diagnosis of moderate to severe Polyarticular Juvenile Idiopathic Arthritis (JIA) and involves multiple joints (polyarticular) ☐ Yes ☐ No
  - Patient had an inadequate response to at least 2 TNF blocking agents? ☐ Yes ☐ No
  - If no, does the patient have a contraindication or intolerance to at least 2 TNF blocking agents? ☐ Yes ☐ No
- Will Orencia be used in combination with another biologic medication? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Orencia® (abatacept)	☐ 250mg Vial*	☐ Infuse _____ mg in 100ml of 0.9% NaCl at weeks 0, 2, and 4, then every 4 weeks thereafter. ☐ Other: __________		
	☐ 125 mg/ML syringe†	☐ Inject 125 mg SC once weekly ☐ Other: __________		

* Maximum quantity is 8 vials for the initial 28 days of therapy, then 4 vials per 28 days.
† For adults with RA only – maximum quantity is 4 syringes per 28 days.

X ______________________________ X ______________________________
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

***IMPORTANT NOTICE:** This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.* *Orencia PAB 121311*