Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	_____/_____/_____ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Orencia IV**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____kg

Patient Height: _____ft _____inches

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process*.

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with question set.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information**.

Site of Care:

A. At what location will the member be receiving the requested medication?

❑ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.

❑ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting.

_____

❑ Other. Please specify. _____

NOTE: Form must be completed in its **entirety** for processing

Criteria Questions:

1. Has the patient been on Orencia continuously for last **6 months**, excluding samples? ***Please select answer below:***
   - ❑ **NO** – this is a PA renewal for **CONTINUATION** of therapy, please answer questions on **continuation section.**
   - ❑ **YES –** this is **INITIATION** of therapy, please answer the following questions:
2. Has the patient had a tuberculin skin test conducted to rule out tuberculosis (TB)? ❑Yes* ❑No
   ***If YES**, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*
   ***If POSITIVE**, has the patient completed treatment or is the patient currently receiving treatment for TB? ❑Yes ❑No
3. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑No
   ***If YES**, has HBV infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No
4. Does the patient have any active infections including TB and HBV? ❑Yes ❑No
5. Will the patient be given live vaccines while on Orencia therapy? ❑Yes ❑No
6. Will Orencia be used in combination with another biologic *disease-modifying anti-rheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No
   ***If YES**, please specify medication: _____
   DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz Tremfya, Truxima, Xeljanz/Xeljanz XR
7. What is the patient's diagnosis?

❑Prophylaxis of Acute Graft Versus Host Disease (aGVHD)

a. Will the patient be undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated-donor? ❑Yes ❑No

b. What is the patient's age? ***Please select answer below***:

❑**Age 2 to 5**: Does the prescriber agree to administer Orencia within the FDA labeled dose of 15mg/kg on the day before transplantation (Day -1), then 12mg/kg on Days 5, 14, and 28 after transplantation? ❑Yes ❑No

❑**Age 6 or Older:** Does the prescriber agree to administer Orencia within the FDA labeled dose of 10mg/kg, with a maximum dose of 1,000mg, on the day before transplantation (Day -1), then Days 5, 14, and 28 after transplantation? ❑Yes ❑No

c. Will Orencia be used in combination with a calcineurin inhibitor and methotrexate? ❑Yes ❑No

❑Juvenile Rheumatoid Arthritis (JRA) **OR** ❑Polyarticular Juvenile Idiopathic Arthritis (pJIA)

a. Is the patient's arthritis active? ❑Yes ❑No

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 1000mg every four weeks? ❑Yes ❑No

c. Does the patient have a contraindication to at least one conventional DMARD? ❑Yes ❑No*
***If NO**, does the patient have an intolerance or have they had an inadequate treatment response to a three-month trial of at least one conventional DMARD? ❑Yes ❑No

❑Psoriatic Arthritis (PsA)

a. Is the patient's arthritis active? ❑Yes ❑No

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 1000mg every four weeks? ❑Yes ❑No

c. Does the patient have a contraindication to at least one conventional DMARD? ❑Yes ❑No*
***If NO**, does the patient have an intolerance or have they had an inadequate treatment response to a three-month trial of at least one conventional DMARD? ❑Yes ❑No

❑Rheumatoid Arthritis (RA)

a. Does the patient have moderate to severely active rheumatoid arthritis? ❑Yes ❑No

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 1000mg every four weeks? ❑Yes ❑No

c. Does the patient have a contraindication to at least one conventional DMARD? ❑Yes ❑No*
***If NO**, does the patient have an intolerance or have they had an inadequate treatment response to a three-month trial of at least one conventional DMARD? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____

CONTINUATION OF ORENCIA INTRAVENOUS THERAPY (PA RENEWAL)

1. Has the patient been on Orencia continuously for last **6 months**, excluding samples? ***Please select answer below***:
   ❑ **NO** – this is **INITIATION** of therapy, please answer questions on **initiation section**.
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
2. What is the patient's diagnosis?
   ❑Juvenile Rheumatoid Arthritis (JRA)
   ❑Polyarticular Juvenile Idiopathic Arthritis (pJIA)
   ❑Psoriatic Arthritis (PsA)
   ❑Rheumatoid Arthritis (RA)
   ❑Other diagnosis ***(please specify):*** _____
3. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 1000mg every four weeks? ❑Yes ❑No
4. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
5. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No
6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
7. Will Orencia be used in combination with another biologic *disease-modifying anti-rheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify: _____
   DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz Tremfya, Truxima, Xeljanz/Xeljanz XR

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**
Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320**