Prior Authorization Request
Nevada Medicaid – Molina Healthcare

Orencia® (abatacept)

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103**.

DATE OF REQUEST:

MEMBER INFORMATION

Last Name, First Name, Middle Initial:		Date of Birth:
Molina ID:	Gender: ☐ Male ☐ Female	Phone:

PRESCRIBING PROVIDER INFORMATION

Name:	NPI:	Specialty:
Phone:	Fax (required):	
Person to contact regarding this request:		

DIAGNOSIS AND REQUESTED DRUG

Name: **Orencia**	Strength:
Dosage:	Duration:

Please document the recipient's diagnosis:

☐ Juvenile Rheumatoid Arthritis ☐ Juvenile Idiopathic Arthritis ☐ Rheumatoid Arthritis
☐ Other:

CLINICAL INFORMATION

Check the applicable boxes to indicate each item as true for the recipient:

☐ The recipient has had a rheumatology consult. Date:_____ Duration of disease:_____ **(if applicable)**.
☐ The recipient has mild disease activity.
☐ The recipient has moderate disease activity.
☐ The recipient has high/severe disease activity.
☐ The recipient has at least 5 swollen joints **(Juvenile Arthritis only)**.
☐ The recipient has at least 3 joints with limitations in motion and pain or tenderness **(Juvenile Arthritis only)**.
☐ The recipient does not have an active infection or history of recurring infections.
☐ The recipient has had a negative tuberculin test prior to initiating requested treatment.
☐ The recipient has had a positive tuberculin test prior to initiating requested treatment.
☐ Treatment with isoniazid was started ≥1 month prior to initiating requested treatment **(only if test was positive)**.
☐ The recipient has an allergy, history of unacceptable/toxic side effects, drug-drug interaction or therapeutic failure with Cimzia®, Enbrel® and Humira® (if indicated for diagnosis). *Please document*:_____
☐ Orencia® is being requested for a unique indication that is supported by peer-reviewed literature or a unique FDA-approved indication (document diagnosis above).

List the medications that were tried and failed for the given diagnosis:

Drug Name	**Reason for Failure**	**Date(s)**

Additional clinical information (if applicable):

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature:_____ **Date:** _____

* Authorization will not be given for the use of more than one biologic at a time (combination therapy).

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.