

ORENCIA® PRIOR REVIEW FAXBACK FORM

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PRESCRIBER NAME	PROVIDER ID/TAX ID <i>(if out of state must have tax ID)</i>	PATIENT NAME	
CONTACT PERSON		BCBSNC ID	
PRESCRIBER PHONE	PRESCRIBER FAX	DATE OF BIRTH	
PRESCRIBER ADDRESS	CITY	STATE	ZIP

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Will the patient be receiving treatment with more than one biologic rheumatoid arthritis agent (Enbrel®, Humira®, Kineret®, Remicade®, Orenzia® or Rituxan®) at the same time?..... Yes No
2. Does the patient have moderate to severe rheumatoid arthritis? Yes No
3. Does the patient have juvenile idiopathic arthritis? Yes No

Other Pertinent Information: _____

I certify that the above information is accurate and **is documented in the medical record.**
 Prescriber's Signature Required: _____ Date _____

If treatment is approved, the coverage duration is 5 years.

For BCBSNC members, fax form to 1-800-795-9403

For NC State Health Plan members, fax form to 1-866-225-5258

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