



**Abatacept (Orencia®)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

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

PLEASE ANSWER THE FOLLOWING QUESTIONS: **Dx Code:** _____

- Will the patient be receiving more than one biologic agent for treatment of rheumatoid arthritis (e.g. Enbrel®, Humira®, Kineret® or Rituxan®) at the same time? Yes No
- Does the patient have moderate to severe rheumatoid arthritis? Yes No
- Does the patient have juvenile idiopathic arthritis? Yes No

*****Effective 10/1/11 Please note: If you are prescribing*

- an intravenous dose of Orencia (medical benefit) over 1000mg every 28 days OR*
- a subcutaneous dose of Orencia (pharmacy benefit) over four doses of 125mg every 28 days please complete and sign page 2.*

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

- If the member will receive subcutaneous Orencia, please verify their pharmacy benefit. If not through BCBSNC, check the specific pharmacy benefits that apply to their plan.
- For BCBSNC members, fax form to 1-800-795-9403
- For NC State Health Plan members (Member ID starting with YPY):
Intravenous-only therapy: Fax form to 1-866-225-5258
Self-administered therapy: Visit www.medco.com/coverage or call 1-800-753-2851

**COMPLETE PAGE 2 ONLY TO REQUEST QUANTITY LIMIT
EXCEPTION FOR ORENCIA**

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If you are requesting a quantity above the amount listed, check the appropriate box and provide the medical necessity of the increased dosage requested.

Please note: These medications require a **prior authorization** before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved. Otherwise, this request will deny.

Dx Code: _____

****Effective 10/1/11 ****

Requested drug doses:

- intravenous dose of Orencia (**medical benefit**) **over 1000mg (four 250 mg vials) every 28 days** OR
 subcutaneous dose of Orencia (**pharmacy benefit**) **over four doses of 125mg every 28 days**
 Provide dosage requested and a description of medical necessity / rationale for this request:

Please certify the following by signing and dating below:

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