CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form

Orencia Intravenous

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone #:		Provider Fax #:	Provider NPI #:
Patient Name:	CCHP Member ID #:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Quantity Dispensed (including units):

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	☐ **Yes** ☐ **No**

Diagnosis:

Please indicate place of administration:
☐ **Physician's Office** ☐ **Hospital/Facility** ☐ **Patient Home** ☐ **Other**

Please provide hospital/facility information: Name: ______ Phone #: ______ Address: ______ ______	Will the drug be: (select one) ☐ **Billed medically using a JCODE** **JCODE:** ☐ **Billed by a pharmacy and delivered to the provider** ☐ **Billed by a pharmacy and delivered to the patient**

Medical History

Please indicate diagnosis:	☐ Rheumatoid Arthritis ☐ Juvenile Idiopathic Arthritis
Please indicate disease severity:	☐ Mild ☐ Moderate ☐ Severe
Date of most recent tuberculosis skin test:	
Result of tuberculosis skin test:	☐ Positive ☐ Negative
Does the member have evidence of infection?	☐ Yes ☐ No
Is the member currently using another TNF-blocking agent or biologic agent in combination with Orencia? *If yes, please indicate drug name:*	☐ Yes ☐ No
Is the member's disease currently active?	☐ Yes ☐ No

Please indicate past medication(s) tried and failed:

Medication name	Start date	End date	Strength	Frequency	Reason for failure, discontinuation
Methotrexate					
Hydroxychloroquine					
Leflunomide					
Minocycline					

Sulfasalazine					
Cimzia					
Enbrel					
Humira					
Remicade					
Simponi					

Please provide any additional clinical information which should be considered in the space below: