

Prior Authorization Request Form for Orenzia for Subcutaneous Administration

Note: Orenzia for intravenous infusion is not covered under the TRICARE Pharmacy Program.



5651

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477 The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TPharmPA@express-scripts.com
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Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php. This prior authorization has no expiration date.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete the clinical assessment:

1. Is Orenzia SQ being used for the treatment of moderately to severely active rheumatoid arthritis in an adult?	Yes Proceed to question 2	No STOP. Coverage not approved
2. Will Orenzia SQ be used in combination with anakinra (Kineret), etanercept (Enbrel), adalimumab (Humira), golimumab (Simponi), certolizumab pegol (Cimzia), or infliximab (Remicade).	Yes STOP. Coverage not approved	No Sign and date below See quantity limits below.
To limit wastage, the maximum quantity of Orenzia that will be dispensed at any one time is 8 weeks supply from the mail order pharmacy and 4 weeks supply from retail network pharmacies as part of the TRICARE Pharmacy (TPharm) Program.		

Step 3 I certify the above is true to the best of my knowledge.

Please sign and date:

_____ Prescriber Signature	_____ Date
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