

## abatacept subcutaneous injection (ORENCIA)

### Diagnoses Considered for Coverage:

- Rheumatoid Arthritis (RA)
- Polyarticular Juvenile Idiopathic Arthritis (pJIA)
- Psoriatic Arthritis (PsA)

### Coverage Criteria:

#### For Rheumatoid Arthritis (RA):

- Diagnosed or prescribed by a rheumatologist, **and**
- Inadequate response, intolerable side effect, or contraindication to methotrexate, **and**
- Not being used in combination with another targeted immunomodulator (i.e. anti-TNFs, IL-6 inhibitors, JAK inhibitors), **and**
- Inadequate response or intolerable side effect with TWO BSC-preferred agents (e.g. Enbrel, Humira, Rinvoq ER, and Xeljanz/Xeljanz XR) OR contraindication to ALL preferred agents, **and**
- Dose does not exceed 125 mg given subcutaneous once per week.

#### For Polyarticular Juvenile Idiopathic Arthritis (pJIA):

- Diagnosed or prescribed by a Rheumatologist, **and**
- Inadequate response or intolerable side effect with two BSC-preferred agents (Enbrel, Humira, Xeljanz), OR contraindication to all preferred agents, **and**
- Not being used together with other targeted immunotherapies (i.e. anti-TNF drugs, interleukin inhibitors), **and**
- Dose does not exceed 125 mg given subcutaneous once per week.

#### For Psoriatic Arthritis:

- Prescribed or recommended by a rheumatologist, **and**
- Inadequate response or intolerable side effect with methotrexate, leflunomide, or sulfasalazine, **and**
- Inadequate response or intolerable side effect with TWO BSC-preferred agents (e.g. Taltz, Enbrel, Humira, Otezla, Stelara, Tremfya, Xeljanz/Xeljanz XR, Skyrizi, and Rinvoq) OR contraindication to ALL preferred agents, **and**
- Not being used together with other targeted immunotherapies (i.e. anti-TNF drugs, interleukin inhibitors, Otezla, JAK inhibitors), **and**
- Dose does not exceed 125 mg subcutaneous once per week.

<b>Coverage Duration:</b> one year	

Effective Date: 1/1/2023