UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1075-14
Program	Prior Authorization/Notification
Medication	*Orencia® (abatacept) *This program applies to the subcutaneous formulation of abatacept
P&T Approval Date	1/2007, 6/2008, 4/2009, 6/2009, 12/2009, 7/2010, 11/2010, 7/2011, 11/2011, 7/2012, 11/2012, 2/2014, 2/2015, 3/2016, 3/2017, 8/2017, 8/2018, 8/2019, 8/2020, 8/2021, 8/2022, 7/2023, 1/2024, 1/2025
Effective Date	4/1/2025

1. Background:

Orencia (abatacept) is a selective T-cell costimulation modulator indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis (RA), patients 2 years of age and older with moderately to severely active polyarticular juvenile idiopathic arthritis (JIA), and patients 2 years of age and older with active psoriatic arthritis (PsA).

Concomitant use of Orencia with other immunosuppressives [e.g., biologic disease-modifying antirheumatic drugs (bDMARDS), Janus kinase (JAK) inhibitors] is not recommended.

2. Coverage Criteria[a]:

A. Rheumatoid Arthritis (RA)

1. **Initial Authorization**

   a. **Orencia** will be approved based on **both** of the following criteria:

      (1) Diagnosis of moderately to severely active rheumatoid arthritis

      -AND-

      (2) Patient is not receiving Orencia in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Simponi (golimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Orencia** will be approved based on **both** of the following criteria:

      (1) Documentation of positive clinical response to Orencia therapy

      -AND-

(2) Patient is not receiving Orencia in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Simponi (golimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

Authorization will be issued for 12 months.

B. Juvenile Idiopathic Arthritis (JIA)

1. **Initial Authorization**

a. **Orencia** will be approved based on **both** of the following criteria:

(1) Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis.

-AND-

(2) Patient is not receiving Orencia in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Simponi (golimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Orencia** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Orencia therapy

-AND-

(2) Patient is not receiving Orencia in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Simponi (golimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

Authorization will be issued for 12 months.

C. Psoriatic Arthritis (PsA)

1. **Initial Authorization**

a. **Orencia** will be approved based on **both** of the following criteria:

(1) Diagnosis of active psoriatic arthritis

-AND-

(2) Patient is not receiving Orencia in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Olumiant (baricitinib), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz (tofacitinib)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Orencia** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Orencia therapy

-AND-

(2) Patient is not receiving Orencia in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Olumiant (baricitinib), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz (tofacitinib)]

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Supply limits, Medical Necessity and/or Step Therapy may be in place.
- The intravenous infusion is typically covered under the medical benefit. Please refer to the United Healthcare Medical Benefit Drug Policy for Orencia.

4. References:

1. Orencia [package insert]. Princeton, NJ: Bristol-Myers Squibb; May 2024.

Program	Prior Authorization/Notification - Orencia (abatacept)
Change Control	
2/2014	Background updated. Concomitant therapy criterion condensed to list four biologic DMARDs and revised to include Xeljanz. Reauthorization criteria revised to standard verbiage and to include concomitant therapy criterion. Extended reauthorization duration to 24 months.
2/2015	Annual review with no change to coverage criteria. Minor reformatting. Updated clinical rules and background.
3/2016	Annual review with no change to the coverage criteria. Updated statement regarding scope of the program. Added reference to UHC drug policy for intravenous infusions. Updated references.

3/2017	Annual review with no change to coverage criteria. Updated background and references.
8/2017	Added psoriatic arthritis to coverage criteria. Updated background and references.
8/2018	Annual review. Added Olumiant (baricitinib) to applicable criteria. Updated background.
8/2019	Annual review with no change to coverage criteria. Updated background and references.
8/2020	Annual review. Updated reauthorization duration to 12 months. Updated background and references.
8/2021	Annual review with no changes to coverage criteria.
8/2022	Annual review with no changes to coverage criteria. Added state mandate footnote. Updated background and reference.
7/2023	Updated not receiving in combination language to targeted immunomodulator and updated examples.
1/2024	Updated Background for updated indication for PsA for patients 2 years of age and older. Updated reference.
1/2025	Annual review. Updated examples with no change to clinical intent. Updated reference.