

Orencia (abatacept)
Effective 08/01/2022

Plan	<input type="checkbox"/> MassHealth <input checked="" type="checkbox"/> MassHealth (PUF) <input type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	Specialty Medications		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Orencia (abatacept) is a selective T cell co-stimulation modulator indicated for:

- Moderately to severely active Rheumatoid Arthritis (RA) in adults
- Moderately to severely active polyarticular Juvenile Idiopathic Arthritis (pJIA) in patients 2 years of age or older
- Active Psoriatic Arthritis (PsA) in adults
- Acute Graft Versus Host Disease (aGVHD) Prophylaxis in adults and pediatrics 2 years of age and older

Coverage Guidelines

Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with Orencia excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.

OR

Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

Moderate to Severe Rheumatoid Arthritis (RA) and Moderate-to-severe Polyarticular juvenile idiopathic arthritis (pJIA)

Prescriber provides documentation of ALL of the following:

1. Appropriate diagnosis
2. **ONE** of the following:
 - a. Paid claims or physician documented inadequate response or adverse reaction to at least **ONE** traditional DMARD or contraindication to traditional DMARDs



- b. Paid claims or physician documented inadequate response or adverse reaction to **ONE** biologic DMARD that is FDA-approved for the requested indication
- 3. Appropriate dosing†

Psoriatic Arthritis

Prescriber provides documentation of **ALL** of the following:

- 1. Appropriate diagnosis
- 2. **ONE** of the following:
 - a. Paid claims or physician documented inadequate response or adverse reaction to **ONE** anti-TNF agent that is FDA-approved for the requested indication
 - b. Contraindication to **ALL** anti-TNF agents that are FDA-approved for the requested indication
- 3. Appropriate dosing†

Acute Graft Versus Host Disease (aGVHD) Prophylaxis

Prescriber provides documentation of **ALL** of the following:

- 1. Appropriate diagnosis
- 2. Member is ≥ 2 years of age
- 3. Orencia will be used in combination with **BOTH** of the following:
 - a. A calcineurin inhibitor
 - b. methotrexate
- 4. Appropriate dosing (weight required)†

† Requests for more frequent or higher doses – See Appendix

Continuation of Therapy

Resubmission by prescriber for any of the following FDA-approved diagnoses will infer a positive response to therapy and request can be recertified if dosing is appropriate.

Limitations

- 1. Initial approvals will be for:
 - a. **All other indications:** 6 months
 - b. **Acute Graft Versus Host Disease (aGVHD) Prophylaxis:** up to 1 month past anticipated date of transplantation
- 2. Reauthorizations will be for:
 - a. **All other indications:** up to 12 months
 - b. **Acute Graft Versus Host Disease (aGVHD) Prophylaxis:** reviewed on a case by case basis
- 3. The following quantity limits apply:

Orencia Inj 50mg/0.4mL	4 units per 28 days
Orencia Inj 87.5mg/0.7mL	
Orencia 125mg/mL	
Orencia Inj 250mg	

Appendix
Appendix A: Dosing

	Pediatric Dosing	Other Dosing												
Orencia® (abatacept)	<p>Juvenile Idiopathic Arthritis (≥ 6 years old, weight < 75 kg): 10 mg/kg IV at weeks 0, 2, and 4, then every 4 weeks thereafter</p> <p>Juvenile Idiopathic Arthritis (≥ 6 years old, weight > 75 kg): Refer to adult IV dosing regimen. Maximum dose: 1,000 mg.</p> <p>Juvenile Idiopathic Arthritis (≥ 2 years old, weight 10 kg to 25 kg): 50 mg SQ every week</p> <p>Juvenile Idiopathic Arthritis (≥ 2 years old, weight 25 to 50 kg): 87.5 mg SQ every week</p> <p>Juvenile Idiopathic Arthritis (≥ 2 years old, weight ≥50 kg): 125 mg SQ every week</p> <p>Acute Graft versus Host prophylaxis (≥ 6 years old): 10 mg/kg (maximum dose: 1,000 mg) IV over 60 minutes on the day before transplantation, followed by Days 5, 14, and 28 after transplantation</p> <p>Acute Graft versus Host prophylaxis (2 to < 6 years old): 15 mg/kg IV over 60 minutes on the day before transplantation, followed by 12 mg/kg IV over 60 min on Days 5, 14, and 28 after transplantation</p>	<p>Rheumatoid arthritis or Psoriatic Arthritis (IV regimen): Dose based on weight infused over 30 minutes at week 0, 2, and 4, then every 4 weeks thereafter.</p> <table border="1"> <thead> <tr> <th>Body weight of patient</th> <th>Dose</th> <th>Number of vials</th> </tr> </thead> <tbody> <tr> <td><60 kg</td> <td>500 mg</td> <td>2</td> </tr> <tr> <td>60 to 100 kg</td> <td>750 mg</td> <td>3</td> </tr> <tr> <td>>100 kg</td> <td>1 gm</td> <td>4</td> </tr> </tbody> </table> <p>Rheumatoid arthritis or Psoriatic Arthritis (SQ regimen): Weight-based IV loading dose (as per above), then 125 mg SQ within 1 day, followed by 125 mg SQ once weekly.</p> <p><u>Unable to receive an IV infusion:</u> Initiate weekly SQ injections without an IV loading dose.</p> <p><u>Transitioning from IV to SQ:</u> administer the first SQ dose instead of the next scheduled IV dose.</p>	Body weight of patient	Dose	Number of vials	<60 kg	500 mg	2	60 to 100 kg	750 mg	3	>100 kg	1 gm	4
Body weight of patient	Dose	Number of vials												
<60 kg	500 mg	2												
60 to 100 kg	750 mg	3												
>100 kg	1 gm	4												

Appendix B: Requests for More Frequent or Higher Doses

Requests for more frequent or higher doses of injectable biologics, may be approved if **ALL** of the following is provided:

1. Documentation of severe disease
2. **ONE** of the following:
 - a. Inadequate response or adverse reaction to **ONE** other injectable biologic which is FDA-approved for the requested indication
 - b. Contraindication to **ALL** other injectable biologics which are FDA-approved for the requested indication
3. Documented partial response to FDA-approved dosing of current biologic therapy
4. Documentation of specialist consult for the requested indication

References

1. Orencia [package insert]. Princeton, NJ: Bristol-Myers Squibb; December 2021.
2. Smolen JS, Landewé R, Billsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update. *Ann Rheum Dis.* 2017;0:1-18.



3. Mease P, Genovese MC, Gladstein G, et al. Abatacept in the treatment of patients with psoriatic arthritis: results of a six-month, multicenter, randomized, double-blind, placebo-controlled, phase II trial. *Arthritis Rheum* 2011; 63:939.
4. Beukelman T, Patkar NM, Saag KG, et al. 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: initiation and safety monitoring of therapeutic agents for the treatment of arthritis and systemic features. *Arthritis Care Res.* 2011;63(4):465-482.
5. Ruperto N, Lovell DJ, Quartier P, et al. Abatacept in children with juvenile idiopathic arthritis: a randomised, double-blind, placebo-controlled withdrawal trial. *Lancet* 2008; 372:383.

Review History

06/26/06 – Reviewed and revised

08/15/06 – Effective

02/25/08 – Reviewed

02/23/09 – Reviewed

02/22/10 – Reviewed

02/28/11 – Reviewed

10/24/11 – Reviewed and revised (09/12/11 drug file Orenzia SQ)

02/27/12 – Reviewed

02/25/13 – Reviewed

02/24/14 – Reviewed

02/23/15 – Reviewed

02/22/16 – Reviewed

02/27/17 – Reviewed and revised (adopted SGM & ST) in P&T Meeting

03/01/18 – Reviewed and revised (adopted MH RS)

02/20/19 – Reviewed in P&T Meeting

10/21/2020 – Reviewed and Updated; separated out Comm/Exch vs. MassHealth. Matched MassHealth Preferred Unified Formulary for implementation 1/1/2021

06/22/2022 – Reviewed and updated for June P&T; matched MH UPPL. Added criteria and approval limitations for newly FDA-approved indication (aGVHD). Continuation of therapy language was updated. Added Appendix B for Requests for More Frequent or Higher Doses. Updated Appendix A: Dosing and References. Effective 08/01/2022.

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