

**Orencia (abatacept)**  
**Effective 11/01/2024**

<b>Plan</b>	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit		
<b>Specialty Limitations</b>	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
<b>Contact Information</b>	<b>Medical and Specialty Medications</b>		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
	<b>Non-Specialty Medications</b>		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029
<b>Exceptions</b>	N/A		

### Overview

Orencia (abatacept) is a selective T cell co-stimulation modulator. It is available in intravenous (IV) and subcutaneous (SC) formulations. Both the IV and SC formulations are indicated for:

- Treatment of adult patients with moderately to severely active rheumatoid arthritis (RA)
- Treatment of patients 2 years of age and older with moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
- Treatment of patients 2 years of age and older with active psoriatic arthritis (PsA)

Additionally, the IV formulation is also approved for the prophylaxis of acute graft versus host disease (aGVHD), in combination with a calcineurin inhibitor and methotrexate, in adults and pediatric patients 2 years of age and older undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor.

### Coverage Guidelines

Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

**OR**

Authorizations may be granted when all the following criteria have been met:

#### Moderately to severely active rheumatoid arthritis (RA)

1. The member has a diagnosis of moderate to severely active rheumatoid arthritis (RA)
2. Member has trial and failure, contraindication or intolerance to TWO of the following:
  - a. Cimzia
  - b. Enbrel
  - c. Humira, Adalimumab-adaz, Adalimumab-fkjp, or Hadlima
  - d. Rinvoq

- e. Simponi
  - f. Xeljanz or Xeljanz XR
3. Member has had minimum duration of a 3-month trial and failure, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses.
    - a. Methotrexate
    - b. Leflunomide
    - c. sulfasalazine

**Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)**

1. The member has a diagnosis of polyarticular juvenile idiopathic arthritis (pJIA)
2. Minimum duration of a 6-week trial and failure, intolerance, or contraindication to ONE of the following conventional therapies at maximally tolerated doses
  - a. Leflunomide
  - b. Methotrexate
3. Member has trial and failure, contraindication or intolerance to TWO of the following:
  - a. Enbrel
  - b. Humira, Adalimumab-adaz, Adalimumab-fkjp, or Hadlima
  - c. Xeljanz or Xeljanz XR
  - d. Rinvoq/Rinvoq LQ

**Active psoriatic arthritis (PsA)**

1. The member has a diagnosis of active psoriatic arthritis (PsA)
2. The member has ONE of the following:
  - a. Actively inflamed joints
  - b. Dactylitis
  - c. Enthesitis
  - d. Axial disease
  - e. Active skin and/or nail involvement
3. Trial and failure, intolerance, or contraindication to TWO of the following:
  - a. Cimzia
  - b. Enbrel
  - c. Humira, Hadlima, Adalimumab-adaz, Adalimumab-fkjp
  - d. Rinvoq/Rinvoq LQ
  - e. Simponi
  - f. Skyrizi
  - g. Stelara
  - h. Tremfya
  - i. Xeljanz/XR

**Prophylaxis for Acute Graft vs. Host Disease (aGVHD)**

1. The member has a diagnosis of prophylaxis for acute Graft vs. Host disease (aGVHD)
2. Member is 2 years of age or older
3. Member will receive hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor
4. Recommended antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation (e.g., acyclovir) will be administered prior to Orenzia and continued for six months after HSCT
5. Medication will be used in combination with BOTH of the following:
  - a. Calcineurin inhibitor (e.g., cyclosporine, tacrolimus)



b. Methotrexate

**Continuation of Therapy**

Authorization of 24 months may be granted for members who achieve or maintain positive clinical response after at least 3 months of therapy with Orencia as evidenced by low disease activity or improvement in signs and symptoms of the condition.

**Limitations**

1. Initial approvals and reauthorizations will be granted for all diagnoses for 24 months

**References**

1. 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.
2. Orencia (abatacept) [prescribing information]. Princeton, NJ: Bristol-Myers Squibb; May 2024.
3. Saag KG, Teng GG, Patkar NM, et al. American College of Rheumatology 2008 recommendations for the use of nonbiologic and biologic disease-modifying antirheumatic drugs in rheumatoid arthritis. *Arthritis Rheum.* 2008;59(6):762-784.
4. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol.* 2016;68(1)1-26.
5. 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.

**Review History**

11/01/2020 – Transitioned from SGM to Custom Criteria; Reviewed and Updated for 2021 strategy to be implemented 1/1/2021.

03/16/2022 – Reviewed and updated for March P&T; Added Rinvoq as preferred trial for PsA under pharmacy benefit. Updated to reflect Inflectra as preferred for Medical Benefit. Effective 05/01/2022.

11/15/2023 – Reviewed and Updated for Nov P&T; Updated preferred agents (consolidated pharmacy and medical benefit preferred drugs required). Removed Appendices. Removed TB requirement. For Psoriatic arthritis: Updated preferred agents to prior use of TWO of the following: Cimzia, Enbrel, Humira or biosimilars, Rinvoq, Simponi, Skyrizi, Stelara, Tremfya, Xeljanz/XR. removed conventional therapies and added examples of active PSA. Rheumatoid arthritis: updated conventional therapies to include methotrexate, leflunomide, sulfasalazine. Updated preferred agents to prior use of TWO of the following: Cimzia, Enbrel, Humira or biosimilars, Rinvoq, Simponi, Xeljanz/XR. Added indication of Prophylaxis for Acute Graft vs. Host Disease (aGVHD). Effective 1/1/2024.

09/11/2024 – Reviewed and updated for September P&T. Updated criteria for pJIA to include Rinvoq and Rinvoq LQ as previous treatment options. Updated PsA criteria to include Rinvoq LQ as a previous treatment option. Effective 11/1/2024.

