PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Benlysta Subcutaneous - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Benlysta Subcutaneous - Priority Partners MCO.

Drug Name (select from list of drugs shown)
BENLYSTA SUBCUTANEOUS (belimumab)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

	[If yes, skip to question 16.]	
2.	Will the requested drug be used for the treatment of severe active central nervous system lupus?	Y N
	[If yes, no further questions.]	
3.	Does the patient have any of the following diagnoses: A) human immunodeficiency virus (HIV), B) hepatitis B virus, C) hepatitis C virus infection?	Y N
	[If yes, no further questions.]	
4.	Has the patient required acute or chronic infection treatment within the past 60 days?	Y N
	[If yes, no further questions.]	
5.	Will the requested medication be used concomitantly with other biologics, calcineurin-inhibitor immunosuppressant or intravenous cyclophosphamide?	Y N
	[If yes, no further questions.]	
6.	Is the requested medication being used for any indications that are not FDA-approved or guideline supported?	Y N
	[If yes, no further questions.]	
7.	Does the patient have a documented diagnosis of active systemic lupus erythematosus (SLE)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 11.]	
8.	Is the patient auto-antibody positive (defined as antinuclear antibody [ANA] titer equals 1:80 or greater OR anti-double stranded deoxyribonucleic acid [anti-dsDNA] equals 30 International Units per milliliter (IU/mL) or higher? Due to lab variability in standards for positive values, consideration will be given if the reported lab results do not meet the values listed above but are reported as "positive" from that lab.	Y N
	NOTE: Submission of lab records is required.	
	[If no, no further questions.]	
9.	Has the patient failed to respond adequately to at least 2 of the following standard therapies: A) corticosteroids, B) non-steroidal anti-inflammatory drugs (NSAIDs), C) anti-malarials (hydroxychloroquine, chloroquine), D) non-biologic immunosuppressants (azathioprine, methotrexate, cyclosporine, oral cyclophosphamide)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
10.	Is the prescriber a rheumatologist?	Y N
	[If yes, skip to question 15.]	
	[If no, no further questions.]	
11.	Does the patient have a diagnosis of active lupus nephritis with renal disease?	Y N

[If no, no further questions.]		
12. Is the patient auto-antibody positive (defined as antinuclear antibody [ANA] titer equals 1:80 or greater OR anti-double stranded deoxyribonucleic acid [anti-dsDNA] equals 30 International Units per milliliter (IU/mL) or higher? Due to lab variability in standards for positive values, consideration will be given if the reported lab results do not meet the values listed above but are reported as "positive" from that lab.	Y N	
NOTE: Submission of lab records is required.		
[If no, no further questions.]		
13. Has the patient failed to respond adequately to at least 2 of the following standard therapies: A) corticosteroids, B) anti-malarials (hydroxychloroquine, chloroquine), D) non-biologic immunosuppressants (azathioprine, methotrexate, cyclosporine, oral cyclophosphamide)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
14. Is the prescriber a rheumatologist or nephrologist?	Y N	
[If no, no further questions.]		
15. Will the patient be utilizing the requested drug with standard therapies?	Y N	
[No further questions.]		
16. Will the requested drug be used for the treatment of severe active central nervous system lupus?	Y N	
[If yes, no further questions.]		
17. Does the patient have any of the following diagnoses: A) human immunodeficiency virus (HIV), B) hepatitis B virus, C) hepatitis C virus infection?	Y N	
[If yes, no further questions.]		
18. Has the patient required acute or chronic infection treatment within the past 60 days?	Y N	
[If yes, no further questions.]		
19. Will the requested medication be used concomitantly with other biologics, calcineurin-inhibitor immunosuppressant or intravenous cyclophosphamide?	Y N	
[If yes, no further questions.]		
20. Is the requested medication being used for any indications that are not FDA-approved or guideline supported?	Y N	
[If yes, no further questions.]		
21. Is there documentation for the patient showing a beneficial response to treatment, evidenced by at least one of the following: A) reduction of daily dosing of required oral corticosteroids, B) documented improvement in functional impairment, or C) reduction in number of symptom	Y N	

exacerbations since starting the requested drug regimen? _____
NOTE: Submission of medical records is required.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date