

Prior Authorization Request Form for
belimumab (**Benlysta**)



JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Is the patient taking concomitant biologics (for example rituximab) and/or intravenous cyclophosphamide?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 2
2. Does the patient have severe active lupus nephritis or severe active central nervous system lupus?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 3
3. Is the patient concurrently taking standard therapy for SLE (for example hydroxychloroquine, systemic corticosteroid and/or immunosuppressives either alone or in combination)?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for Benlysta</i>	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Proceed to question 5
5. Is the patient GREATER THAN or EQUAL to 5 years of age?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Does the patient have a documented diagnosis of active, autoantibody positive (that is positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]) systemic lupus erythematosus (SLE)?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

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7. Is the requested medication being prescribed by or consultation with a specialty provider for systemic lupus erythematosus (SLE): rheumatologist, cardiologist, neurologist, nephrologist, immunologist, or dermatologist?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
8. Has treatment with Benlysta shown documented clinical benefit (that is improvement in number/frequency of flares, improvement in in Safety of Estrogen in Lupus Erythematosus National Assessment - SLE Disease Activity Index (SELENA-modified SLEDAI) score, improvement/stabilization of organ dysfunction, improvement in complement levels/lymphocytopenia, etc.)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature

_____ Date

[4 December 2019]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: