



## Benlysta

### Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

**Referring Provider Info:**  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Rendering Provider Info:**  Same as Referring Provider  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

**Required Demographic Information:**

*Patient Weight:* \_\_\_\_\_ *kg*

*Patient Height:* \_\_\_\_\_ *cm*

**Drug Information:**

*Strength/Measure* \_\_\_\_\_ *Units*  ml  Gm  mg  ea  Un

*Directions(sig)* \_\_\_\_\_ *Route of administration* \_\_\_\_\_

*Dosing frequency* \_\_\_\_\_

**Send completed form to: Priority Partners Fax: 1-866-212-4756**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. JHHC SOC Benlysta SGM – 11/2021.

**Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076**

**Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com**

**Site of Service Questions:**

- A. Indicate the site of service requested:  
 On Campus Outpatient Hospital  Off Campus Outpatient Hospital  
 Home based setting, *skip to Criteria Questions*  Community office, *skip to Criteria Questions*  
 Ambulatory infusion site, *skip to Criteria Questions*
- B. Is the patient less than 18 years of age?  
 Yes, *skip to Clinical Criteria Questions*  
 No
- C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***  Yes, *skip to Clinical Criteria Questions*  No
- D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?  
***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***  
 Yes, *skip to Clinical Criteria Questions*  No
- E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***  
 Yes, *skip to Clinical Criteria Questions*  No
- F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***  
 Yes, *skip to Clinical Criteria Questions*  No
- G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***  
 Yes, *skip to Clinical Criteria Questions*  No
- H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?  
***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***  Yes  No

**Clinical Criteria Questions:**

1. What is the patient's diagnosis?  
 Active systemic lupus erythematosus (SLE)  
 Active lupus nephritis  
 Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Will the patient be using the requested drug in combination with other biologics?  Yes  No
4. Is the patient currently receiving treatment with the requested medication?  Yes  No *If No, skip to #6*
5. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition? ***ACTION REQUIRED: If 'Yes', attach medical records (e.g., chart notes, lab reports) documenting disease stability or improvement.***  Yes  No *No further questions*

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6. Does the patient have severe active central nervous system (CNS) lupus [including seizures that are attributed to CNS lupus, psychosis, organic brain syndrome, cerebrovascular accident, cerebritis, or CNS vasculitis requiring therapeutic intervention within 60 days before initiation of belimumab (Benlysta)]?  Yes  No

**Complete the following section based on the patient's diagnosis, if applicable.**

**Section A: Systemic lupus erythematosus (SLE)**

7. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus?  
**ACTION REQUIRED: If 'Yes', attach medical records (e.g., chart notes, lab reports) documenting the presence of autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm).**  
 Yes  No  Unknown
8. Is the patient currently receiving a stable standard treatment regimen for systemic lupus erythematosus (SLE) with any of the following (alone or in combination)?  
 Glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone)  
 Antimalarials (e.g., hydroxychloroquine)  
 Immunosuppressives (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide)  
 None of the above

**Section B: Active lupus nephritis**

9. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus?  
Action Required: If 'Yes', attach medical records (e.g., chart notes, lab reports) documenting the presence of autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm).  
 Yes  No  Unknown
10. Does the patient have clinically active lupus renal disease?  Yes  No
11. Is the patient currently receiving a stable standard induction and maintenance treatment for lupus nephritis (e.g., cyclophosphamide, mycophenolate mofetil, azathioprine, glucocorticoids)?  Yes  No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

X \_\_\_\_\_

**Prescriber or Authorized Signature**

**Date (mm/dd/yy)**

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