



<b>Prior Authorization</b>
JOHNS HOPKINS HEALTHCARE (MEDICAID) 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 Healthcare at <b>1-410-424-4607</b> . Please contact Johns Hopkins Healthcare at <b>1-888-819-1043</b> 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) <b>BENLYSTA SUBCUTANEOUS (belimumab)</b>
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Quantity	Frequency	Strength	
Route of Administration	Expected Length of Therapy		

<b>Patient Information</b>	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

<b>Prescribing Physician</b>	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
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Comments: _____
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<b>Please circle the appropriate answer for each question.</b>	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> 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 12.]	

2. Will the requested drug be used for the treatment of either of the following conditions: A) severe active lupus nephritis, or B) severe active central nervous system lupus?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
4. Has the patient required acute or chronic infection treatment within the past 60 days?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
5. Does the patient have a documented diagnosis of active systemic lupus erythematosus (SLE)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Is the prescriber a rheumatologist?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
7. 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)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of lab records is required. 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.	
[If no, no further questions.]	
8. 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)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Will the patient be utilizing the requested drug with standard therapies?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
10. Will the requested drug be concomitantly used with other biologics, or intravenous (IV) cyclophosphamide?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
11. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	

12. 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 exacerbations since starting the requested drug regimen?

Y N

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**