PRIOR AUTHORIZATION REQUEST
Benlysta

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Systemic lupus erythematosus (SLE)
   - ☐ Rheumatoid arthritis (RA)
   - ☐ All others (Please specify): _____
2. Will the requested medication be used in combination with other biologics or with cyclophosphamide intravenous (IV)?
   - ☐ Biologic
   - ☐ Cyclophosphamide intravenous (IV)
   - ☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or cyclophosphamide intravenous (IV)
3. ☐ Yes ☐ No Is this medication being prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist?
4. ☐ Yes ☐ No Is the requested medication being used concurrently with at least one other standard therapy?
5. ☐ Yes ☐ No As determined by the prescriber, is the patient intolerant to standard therapy due to a significant toxicity?
6. ☐ Yes ☐ No Is the patient currently receiving Benlysta subcutaneous or intravenous?
7. ☐ Yes ☐ No Does the patient have autoantibody-positive SLE, defined as positive for antinuclear antibodies (ANA) or anti-double-stranded DNA antibody (anti-dsDNA)?
8. ☐ Yes ☐ No Has the patient responded to Benlysta subcutaneous or intravenous, as determined by the prescriber?

Please document the diagnoses, symptoms, and/or any other information important to this review:

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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