maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Benlysta SQ

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the requested medication be used in combination with other Biologics? [Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV products (for example, Remicade, biosimilars), a rituximab IV products (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC).] [If yes, no further questions.]	Yes	No
2	Is the patient currently receiving the requested medication? [If no, skip to question 13.]	Yes	No

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 13.]	Yes	No
4	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 6.]	Yes	No
5	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 13.] [If no, no further questions.]	Yes	No
6	Has the patient been established on therapy for at least 4 months? [If no, skip to question 13.]	Yes	No
7	What is the diagnosis or indication? [] Lupus nephritis (If checked, go to 8) [] Systemic lupus erythematosus (If checked, go to 10) [] Rheumatoid arthritis (If checked, no further questions) [] Other (If checked, no further questions)		
8	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of a response include improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, and improvement in complement levels (for example, C3, C4).] [If no, no further questions.]	Yes	No
9	Is the requested medication being used concurrently with at least one other standard therapy? [Note: Examples of standard therapies include azathioprine, mycophenolate mofetil, cyclophosphamide.] [If yes, no further questions.] [If no, skip to question 12.]	Yes	No
10	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of a response include reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, improvement in complement levels (for example, C3, C4), or improvement in specific organ dysfunction (for	Yes	No

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	example, musculoskeletal, blood, hematologic, vascular, others).] [If no, no further questions.]		
11	Is the requested medication being used concurrently with at least one other standard therapy? [Note: Examples of standard therapies include an antimalarial (for example, hydroxychloroquine), systemic corticosteroid (for example, prednisone), and other immunosuppressants (for example, azathioprine, mycophenolate mofetil, methotrexate).] [If yes, no further questions.]	Yes	No
12	As determined by the prescriber, is the patient intolerant to standard therapy due to a significant toxicity? [No further questions.]	Yes	No
13	Is the patient greater than or equal to 5 years of age? [If no, no further questions.]	Yes	No
14	What is the diagnosis or indication? [] Lupus nephritis (If checked, go to 15) [] Systemic lupus erythematosus (If checked, go to 20) [] Rheumatoid arthritis (If checked, no further questions) [] Other (If checked, no further questions)		
15	Does the patient have autoantibody-positive systemic lupus erythematosus (SLE), defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA antibody (anti-dsDNA)? [If no, no further questions.]	Yes	No
16	Has the patient had an inadequate response to at least two of the following: A) corticosteroids, B) azathioprine, C) cyclophosphamide, or D) mycophenolate? [if no, no further questions.]	Yes	No
17	Will the requested medication be used in combination with at least one other standard therapy? [Note: Examples of standard therapies include azathioprine, mycophenolate mofetil, cyclophosphamide.] [If yes, skip to question 19.]	Yes	No
18	As determined by the prescriber, is the patient intolerant to standard therapy due to a significant toxicity? [If no, no further questions.]	Yes	No
19	Is the requested medication being prescribed by or in consultation with a nephrologist or rheumatologist?	Yes	No

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	[No further questions.]		
20	Does the patient have autoantibody-positive systemic lupus erythematosus (SLE), defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA antibody (anti-dsDNA)? [Note: Not all patients with SLE are positive for anti- dsDNA, but most will be positive for ANA.] [If no, no further questions.]	Yes	No
21	Has the patient had an inadequate response to at least two of the following: A) corticosteroids, B) antimalarials (hydroxychloroquine, chloroquine), C) NSAIDs, D) aspirin, and/or E) immunosuppressives such as azathioprine, methotrexate, mycophenolate? [If no, no further questions.]	Yes	No
22	Will the requested medication be used in combination with at least one other standard therapy? [Note: Examples of standard therapies include an antimalarial (for example, hydroxychloroquine), systemic corticosteroid (for example, prednisone), and other immunosuppressants (for example, azathioprine, mycophenolate mofetil, methotrexate).] [if yes, skip to question 24.]	Yes	No
23	As determined by the prescriber, is the patient intolerant to standard therapy due to a significant toxicity? [If no, no further questions.]	Yes	No
24	Is the requested medication being prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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authorization as per Plan policy and procedures.