PRIOR AUTHORIZATION REQUEST

BENLYSTA

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request for an INITIAL or a CONTINUATION of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	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	Yes	No

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	etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV products (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.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved prior authorization (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 no, skip to question 8.]	Yes	No
6	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	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 (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
9	What is the indication or diagnosis? [] Lupus nephritis (If checked, go to 10) [] Systemic lupus erythematosus (If checked, go to 17) [] Rheumatoid arthritis (If checked, no further questions) [] Other (If checked, no further questions)		
10	Is the patient greater than or equal to 5 years of age? [If no, no further questions.]	Yes	No

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11	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
12	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
13	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, skip to question 15.]	Yes	No
14	Is the patient intolerant to standard therapy due to a significant toxicity as determined by the prescriber? [If no, no further questions.]	Yes	No
15	Is the requested medication being prescribed by or in consultation with a nephrologist or rheumatologist? [If no, no further questions.]	Yes	No
16	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: Adult - 400 mg once weekly for 4 doses, then 200 mg once weekly thereafter; 15 kg to 40 kg pediatric patient - 200 mg once weekly for 4 doses, then 200 mg once every 2 weeks; greater than or equal to 40 kg pediatric patient - 400 mg once weekly for 4 doses, then 200 mg every 2 weeks thereafter.] [No further questions.]	Yes	No
17	Is the patient greater than or equal to 5 years of age? [If no, no further questions.]	Yes	No
18	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
19	Has the patient had an inadequate response to BOTH of the following: A) Antimalarials (hydroxychloroquine, chloroquine), and B) Immunosuppressives such as azathioprine, methotrexate, mycophenolate? [If no, no further questions.]	Yes	No

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20	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 22.]	Yes	No
21	Is the patient intolerant to standard therapy due to a significant toxicity, as determined by the prescriber? [If no, no further questions.]	Yes	No
22	Is the requested medication being prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist? [If no, no further questions.]	Yes	No
23	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: Adult - 200 mg once weekly; 15 kg to 40 kg pediatric patient - 200 mg once every 2 weeks, pediatric patient greater than or equal to 40 kg - 200 mg once weekly.]	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 authorization as per Plan policy and procedures.

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If you have any questions, call: 1-888-258-8250