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

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:

What is the ICD-10 Code? _____

1. What is the patient's diagnosis?

❒ Active systemic lupus erythematosus (SLE), *Continue to 2*

❒ Active lupus nephritis, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 3*

❒ No, *Continue to 5*

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3. 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, *Continue to 4*

❒ No, *Continue to 4*

4. Will the patient be using the requested drug in combination with other biologics?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

5. Does the patient have severe active central nervous system (CNS) lupus [including seizures that are attributed to CNS lupus, psychosis, organic brain syndrome, cerebritis, or CNS vasculitis requiring therapeutic intervention within 60 days before initiation of the requested drug]?

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. Will the patient be using the requested drug in combination with other biologics?

❒ Yes, *Continue to 7*

❒ No, *Continue to 7*

7. What is the patient's diagnosis?

❒ Active systemic lupus erythematosus (SLE), *Continue to 8*

❒ Active lupus nephritis, *Continue to 10*

8. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus (SLE) (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins)? ***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, antiphospholipid antibodies, complement proteins).

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

❒ Unknown, *Continue to 9*

9. Is the patient currently receiving a stable standard treatment regimen for systemic lupus erythematosus (SLE) with any of the following (alone or in combination)?

❒ Yes, glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone), *No Further Questions*

❒ Yes, antimalarials (e.g., hydroxychloroquine), *No Further Questions*

❒ Yes, immunosuppressives (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide), *No Further Questions*

❒ Yes, nonsteroidal anti-inflammatory drugs (NSAIDs, e.g., ibuprofen, naproxen), *No Further Questions*

❒ No, *No Further Questions*

10. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus (SLE) (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins) or was lupus nephritis confirmed on kidney biopsy? ***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, antiphospholipid antibodies, complement proteins).

❒ Yes, *Continue to 11*

❒ No, *Continue to 11*

❒ Unknown, *Continue to 11*

11. Is the patient currently receiving a stable standard therapy regimen for lupus nephritis (e.g., cyclophosphamide, mycophenolate mofetil, azathioprine, glucocorticoids)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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