HEALTHY U MEDICAID

PHARMACY PRIOR AUTHORIZATION REQUEST FORM
BENLYSTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Benlysta® (belimumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
SYSTEMIC LUPUS ERYTHEMATOSUS			
1. Does the member have a confirmed diagnosis of active moderate to severe systemic lupus erythematosus?	☐	☐	**Please provide documentation**
2. Does member meet age requirements for the requested formulation? • Member must be ≥5 years for intravenous administration. NOTE: Intravenous administration is non-preferred for members > 80 kg • Member must be ≥18 years for subcutaneous administration.	☐	☐	
3. Is the request made by, or in consultation with, a rheumatologist?	☐	☐	
4. Does the member have a Safety of Estrogen in Lupus National Assessment-Systemic Lupus Erythematosus Disease Activity Index (SELENA-SLEDAI) score of ≥ 6?	☐	☐	**Please provide documentation**
5. Does the member have active musculoskeletal or cutaneous disease that is unresponsive to standard therapy with glucocorticoids and/or other immunosuppressive agents?	☐	☐	**Please provide documentation**

6. Is there documentation of corticosteroid-dependent disease (prednisone equivalent dose ≥10mg/day) OR trial and failure of both hydroxychloroquine AND at least 1 immunosuppressant (e.g., azathioprine, methotrexate, mycophenolate)?	☐	☐	**Please provide documentation**
7. Has the member been at least 80% compliant for at least 6 months with their baseline therapy (i.e., steroids and/or immunosuppressants)?	☐	☐	**Please provide documentation**
8. Will Benlysta® be used concurrently with baseline therapy?	☐	☐	**Please provide documentation**
9. Does the member have documentation of active central nervous system lupus (e.g. generalized seizures, psychosis, stroke, peripheral neuropathies)?	☐	☐	**Please provide documentation**
10. Has the member received any other biologics, immunoglobulins, IV cyclophosphamide, or prednisone >100mg daily within the last 6 months?	☐	☐	**Please provide documentation**
LUPUS NEPHRITIS			
1. Does the member have a confirmed diagnosis of lupus nephritis?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, a nephrologist or rheumatologist?	☐	☐	
3. Did the member have a kidney biopsy showing a histological diagnosis of lupus nephritis Class III, IV or V?	☐	☐	**Please provide documentation**
4. Does documentation show a recent eGFR ≥ 30 mL/min/1.73m^2?	☐	☐	**Please provide documentation**
5. Has the member had dialysis in the past 12 months?	☐	☐	
6. Is the member currently receiving standard immunosuppressive therapy for systemic lupus erythematosus?	☐	☐	**Please provide documentation**
7. Will Benlysta® be used concurrently with baseline therapy?	☐	☐	**Please provide documentation**
8. Does the member have active central nervous system lupus (e.g. generalized seizures, psychosis, stroke, peripheral neuropathies)?	☐	☐	**Please provide documentation**
9. Has the member received any other biologics, immunoglobulins, IV cyclophosphamide, or prednisone >100mg daily within the last 6 months?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
SYSTEMIC LUPUS ERYTHEMATOSUS			
1. Is the request for reauthorization of therapy for systemic lupus erythematosus?	☐	☐	
2. Does clinical documentation show continued medical necessity, as well as efficacy and tolerability of therapy?	☐	☐	**Please provide documentation**
3. Does documentation show continued use of baseline therapy?	☐	☐	**Please provide documentation**
LUPUS NEPHRITIS			
1. Is the request for reauthorization of therapy for lupus nephritis?	☐	☐	
2. Has the member had an improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer and/or improvement in complement levels?	☐	☐	**Please provide documentation**
3. Does documentation show continued use of standard therapy during Benlysta® administration?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

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Policy: PHARM-HU-081
Origination Date: 01/01/2022
Reviewed/Revised Date: 01/18/2023
Next Review Date: 01/18/2024
Current Effective Date: 02/01/2023