Benlysta SQ (belimumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

Revision Date: 6/15/24

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Systemic lupus erythematosus (SLE) WITHOUT active lupus nephritis □ Systemic lupus erythematosus WITH active Lupus nephritis □ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is the patient using the drug in combination with a clinical trial? □ Yes □ No

Is the patient's SLEDAI (SLE Activity Index) score greater than or equal to 6? □ Yes □ No

Is the patient positive for antinuclear antibodies > 1:80 and/or anti-double-stranded DNA (anti-dsDNA) antibodies?* □ Yes □ No **Please submit chart notes with lab results.*

Does the patient have severe lupus kidney disease (proteinuria greater than 6 g/24 hrs or equivalent OR serum creatinine greater than 2.5 mg/dL)? □ Yes □ No

Does the patient have severe CNS (central nervous system) lupus? □ Yes □ No

Select if the patient has tried the following medications:*

□ Non-steroidal anti-inflammatory drugs (NSAIDs)

□ An anti-malarial (Plaquenil and/or hydroxychloroquine)

□ A corticosteroid

□ An immunosuppressive (azathioprine, mycophenolate, methotrexate)

****Please submit documentation*.**

Does the patient have active biopsy-proven lupus nephritis? □ Yes □ No **Please submit documentation.*

Does patient have a urinary protein-to-creatinine ratio equaling 1 or greater? □ Yes □ No
****Please submit chart notes with lab results.***

Is patient's lupus nephritis ISN/RPS class III, class IV, or class V? □ Yes □ No **Please submit chart notes with pathology report, which documents the prescence of active lesions.*

Does the patient's estimated GFR equal 30 ml/min/1.73m^2 or greater? □ Yes □ No **Please submit chart documentation with lab report.*

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Has patient failed BOTH cyclophosphamide AND mycophenolate induction therapy? □ **Yes** □ **No** ***Please submit documentation.***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811