HEALTH PLANS
UNIVERSITY OF UTAH

PHARMACY PRIOR AUTHORIZATION REQUEST FORM
BENLYSTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

- For **Medical Pharmacy** please fax requests to 801-213-1547.
- For **Retail Pharmacy** requests please fax requests to: 888-509-8142

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

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
1. Does the member have a confirmed diagnosis of active moderate to severe systemic lupus erythematosus?	☐	☐	**Please provide documentation**
2. Does the member have a positive autoantibody test (e.g., anti-nuclear antibody [ANA] greater than laboratory reference range and/or anti-double-stranded DNA [anti-dsDNA] greater than 2 fold the laboratory reference range if test by ELISA)?	☐	☐	**Please provide documentation**
3. Does member meet age requirements for the requested formulation? • Member must be ≥5 years for intravenous administration. Intravenous administration is non-preferred for members > 100 kg • Member must be ≥18 years for subcutaneous administration.	☐	☐	
4. Is the prescribing provider a rheumatologist?	☐	☐	
5. Does the member have a Safety of Estrogen in Lupus National Assessment-Systemic Lupus Erythematosus Disease Activity Index (SELENA-SLEDAI) score?	☐	☐	**Please provide documentation**

6. 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**
7. 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**
8. Has the member shown to be at least 80% compliant for at least 6 months with their baseline therapy (i.e., steroids and/or immunosuppressants)?	☐	☐	**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			
1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Has the member had a reduction in the number of severe flares AND response in the SLE responder index (SRI)? • Defined as ≥ 4 point reduction from baseline in SELENA-SLEDAI score, no new BILAG-A organ domain score, ≤ 1 new BILAG-B score, and < 0.3 point increase in physician's global assessment score from baseline.	☐	☐	**Please provide documentation**
3. Does documentation show continued use of standard therapy during Benlysta® administration with one or more of the following medications, unless otherwise contraindicated: • oral antimalarials • immunosuppressants • corticosteroids	☐	☐	**Please provide documentation**
4. Has the member received any other biologics, immunoglobulins, IV cyclophosphamide, or prednisone >100mg daily within the last 6 months?	☐	☐	**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:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

PHARM- 081
Origination Date: 08/21/2019
Reviewed/Revised Date: 10/28/2020
Next Review Date: 10/28/2021
Current Effective Date: 11/01/2020