AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – Benlysta

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

**Prescriber Information**

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days

**Clinical Information**

**Initial Authorization (answer questions 1-7):**

1. Does the beneficiary have a diagnosis of active systemic lupus erythematosus (SLE)? Yes___ No___
2. Does the beneficiary have a diagnosis of Lupus Nephritis? Yes___ No___
3. Is the medication being prescribed by or in consultation with a rheumatologist? Yes___ No___
4. Is the beneficiary auto-antibody positive? Yes___ No___
5. Is the beneficiary utilizing the medicine in combination with standard treatment regimens (NSAIDs, corticosteroids, anti-malarials, or immunosuppressive drugs) or standard treatment regimens were not tolerated or beneficial? Yes___ No___
6. Does the beneficiary have a diagnosis of severe active lupus nephritis or severe active central nervous system lupus? Yes___ No___
7. Is the medication being used concurrently with other biologics and/or IV cyclophosphamide? Yes___ No___

**Reauthorization (answer question 8):**

8. Is there documented improvement in functional impairment such as fewer flares that required steroid treatment, lower average daily oral prednisone dose, improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits, or sustained improvement in laboratory measures of lupus activity? Yes___ No___

****Please attach current progress notes documenting disease status and clinical response to the medicine.****

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**