Updated: 02/2020
DMMA Approved: 02/2020

Request for Prior Authorization for Benlysta (belimumab)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Benlysta (belimumab) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Benlysta (belimumab) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of active systemic lupus erythematosus and the following criteria is met:

- The member is 5 years of age or older
- Must be prescribed by or in consultation with a rheumatologist or hematologist
- The member's disease is active as evidenced by a SELENA-SLEDAI score of 6 or greater prior to initiation of therapy
- Must be autoantibody-positive confirmed by documentation of one of the following:
  - anti-nuclear antibody (ANA) titer ≥ 1:80
  - anti-double stranded DNA (anti-dsDNA) ≥ 30 IU/mL
- Must be currently taking or has tried and failed or had an intolerance or contraindication to at least one standard therapy for SLE (e.g. corticosteroids, antimalarials, NSAIDS, or immunosuppressives)
- Must not have severe active lupus nephritis or severe active central nervous system (CNS) lupus
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- **Initial Duration of Approval:** 12 months
- **Reauthorization Criteria:** chart documentation demonstrating clinical benefit and tolerance to Benlysta.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK. Delaware HEALTH OPTIONS

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BENLYSTA (BELIMUMAB) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158

If needed, you may call to speak to a Pharmacy Services Representative.

PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Systemic lupus erythematosus ☐ Other: _____ ICD-10: _____

- Does the member have active disease? ☐ Yes ☐ No
- Please provide member's baseline SELENA-SLEDAI score: _____
- Is the anti-nuclear antibody (ANA) titer ≥ 1:80? ☐ Yes ☐ No
- Is the anti-double stranded DNA (anti-dsDNA) ≥ 30 IU/mL? ☐ Yes ☐ No

Has the member tried other medications for SLE? ☐ Yes, see list below ☐ No

Does the member have severe active lupus nephritis or severe active central nervous system (CNS) lupus? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member tolerated and experienced a clinical benefit from treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date