Updated: 02/2019
PARP Approved: 02/2019

Prior Authorization Criteria

Benlysta (belimumab)

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

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

- The member is 18 years of age or older
- Must be prescribed by or in consultation with a rheumatologist
- 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 receiving 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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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 Gateway Health[SM] Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 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:
Gateway 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:

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