carolina complete health

Pharmacy Prior Approval Request for Lupus Medications

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Initial authorization (answer questions 1-10)

1. Is the medication being prescribed by or in consultation with a rheumatologist or nephrologist? ☐ **Yes** ☐ **No**
2. Is the member ≥ 18 years of age or older? ☐ **Yes** ☐ **No**
3. Does the member have a diagnosis of active systemic lupus erythematosus (SLE)? ☐ **Yes** ☐ **No**
4. Is the member auto-antibody positive? ☐ **Yes** ☐ **No**
5. Is the member 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. Is the medication being used concurrently with other biologics and/or IV cyclophosphamide? ☐ **Yes** ☐ **No**
7. Does the member have a diagnosis or severe active central nervous system lupus? ☐ **Yes** ☐ **No**

OR

8. Does the member have a diagnosis of active lupus nephritis? ☐ **Yes** ☐ **No**
9. Is the member utilizing the medicine in combination with standard treatment regimens (immunosuppressive therapy) with the exception of cyclophosphamide? ☐ **Yes** ☐ **No**
10. Does the member have baseline blood pressure < 165/105 mg Hg, estimated glomerular filtration rate is > 45 mL/min/1.73 m^2

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For re-authorization (answer questions below)

11. 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**

12. Is there documentation of any treatment restricting adverse effects (e.g. hypertension, neurotoxicities, hyperkalemia)

****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: (866) 399-0929

Pharmacy PA Call Center: (833) 585-4309