carolina complete health

Pharmacy Prior Approval Request for
Lupus Medications- BENLYSTA

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 1-7)

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**

For re-authorization (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: (866) 399-0929 Pharmacy PA Call Center: (833) 585-4309