



## Benlysta IV

### Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copy or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

**Referring Provider Info:**  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Rendering Provider Info:**  Same as Referring Provider  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

**Required Demographic Information:**

*Patient Weight:* \_\_\_\_\_ *kg*

*Patient Height:* \_\_\_\_\_ *cm*

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

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Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

**Site of Service Questions:**

- A. Where will this drug be administered?
- |   |   |
|---|---|
| <input type="checkbox"/> Ambulatory surgical, <i>skip to Clinical Questions</i> | <input type="checkbox"/> Home infusion, <i>skip to Clinical Questions</i> |
| <input type="checkbox"/> Off-campus Outpatient Hospital                         | <input type="checkbox"/> On-campus Outpatient Hospital                    |
| <input type="checkbox"/> Physician office, <i>skip to Clinical Questions</i>    | <input type="checkbox"/> Pharmacy, <i>skip to Clinical Questions</i>      |
- B. How many doses of the requested product has the patient received?
- 2 or more doses → This is a continuation of an existing treatment.
- 0 to 1 dose → This is a new request OR the patient has received only 1 dose. *skip to Clinical Criteria Questions*
- C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.***  Yes, *skip to Clinical Criteria Questions*  No
- D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?  
***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.***  
 Yes, *skip to Clinical Criteria Questions*  No
- E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.***  
 Yes, *skip to Clinical Criteria Questions*  No
- F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.***  Yes, *skip to Clinical Criteria Questions*  No
- G. Are alternative infusion sites (pharmacy, physician office, ambulatory care, etc) not within a reasonable distance from the patient's home? ***ACTION REQUIRED: If Yes, Attach supporting documentation.***  Yes  No

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**Clinical Criteria Questions:**

1. What is the patient's diagnosis?  
 Active systemic lupus erythematosus (SLE)  
 Active lupus nephritis  
 Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Will the patient be using Benlysta in combination with other biologics?  Yes  No
4. Is the patient currently receiving treatment with the requested medication?  Yes  No *If No, skip to #6*
5. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition?  Yes  No *No further questions*
6. Does the patient have severe active central nervous system (CNS) lupus [including seizures that are attributed to CNS lupus, psychosis, organic brain syndrome, cerebrovascular accident, cerebritis, or CNS vasculitis requiring therapeutic intervention within 60 days before initiation of belimumab (Benlysta)]?  Yes  No

***Complete the following section based on the patient's diagnosis, if applicable.***

**Section A: Systemic lupus erythematosus (SLE)**

7. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus?  
 Yes  No  Unknown
8. Is the patient currently receiving a stable standard treatment regimen for systemic lupus erythematosus (SLE) with any of the following (alone or in combination)?  
 Glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone)  
 Antimalarials (e.g., hydroxychloroquine)  
 Immunosuppressives (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide)  
 None of the above

**Section B: Active lupus nephritis**

9. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus?  
 Yes  No  Unknown
10. Is the patient currently receiving a stable standard induction and maintenance treatment for lupus nephritis (e.g., cyclophosphamide, mycophenolate mofetil, azathioprine, glucocorticoids)?  Yes  No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X** \_\_\_\_\_

**Prescriber or Authorized Signature**

**Date (mm/dd/yy)**

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