Trillium Health Resources
Pharmacy Prior Approval Request for

Lupus: Benlysta

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Benlysta** 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. 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 member have a diagnosis of active systemic lupus erythematosus (SLE)? ☐ **Yes** ☐ **No**
2. Does the member 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 member auto-antibody positive? ☐ **Yes** ☐ **No**
5. Is the member utilizing the medicine in combination with standard treatment regimens (NSAIDs, corticosteroids, anti-malarial, or immunosuppressive drugs) or standard treatment regimens were not tolerated or beneficial? ☐ **Yes** ☐ **No**
6. Does the member 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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277