BlueCross BlueShield Federal Employee Program

BENLYSTA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Benlysta (belimumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of lupus nephritis or systemic lupus erythematosus (SLE)? ❑Yes* ❑No

If YES, please select answer below:

❑ **Yes, lupus nephritis**

a. Is the patient receiving standard therapy (e.g., corticosteroids, cyclosporine, tacrolimus, cyclophosphamide, azathioprine, mycophenolate, and rituximab)? ❑Yes ❑No

b. **Age 5-17**: Will the patient be receiving Benlysta as intravenous infusion (IV)? ❑Yes ❑No

c. Has the patient been on Benlysta continuously for the last **4 months**, excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following question:

i. Is the patient's lupus nephritis active? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Does the patient have a documented clinical benefit from therapy (i.e., decrease or stabilization of symptoms, improvement in functional impairment, decrease of corticosteroid dose, decrease in pain medications, decrease in the number of exacerbations since prior to the start of Benlysta)? ❑Yes ❑No

❑ **Yes, systemic lupus erythematosus (SLE)**

a. Is the patient receiving standard therapy [e.g., corticosteroids, NSAID, azathioprine, leflunomide, methotrexate, mycophenolate, tacrolimus, and antimalarial (e.g., hydroxychloroquine, chloroquine, quinine, quinidine, mefloquine)]? ❑Yes ❑No

b. Has the patient been on Benlysta continuously for the last **4 months**, excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Is the patient's systemic lupus erythematosus active? ❑Yes ❑No

ii. Is the patient autoantibody-positive? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Does the patient have a documented clinical benefit from therapy (e.g., improvement in functional impairment, decrease of corticosteroid dose, decrease in pain medications, decrease in the number of exacerbations since prior to the start of Benlysta)? ❑Yes ❑No

2. Does the prescriber agree to review and discuss with Black/African American patients the limited evidence of benefit of Benlysta in this population compared to standard treatment? ❑Yes ❑No ❑Patient is not Black/African American
3. Does the patient have a chronic infection, including, but not limited to Hepatitis B, Hepatitis C, HIV, or TB? ❑Yes ❑No
4. Does the patient have severe active central nervous system lupus? ❑Yes ❑No
5. Will the patient be given live vaccines while on Benlysta? ❑Yes ❑No
6. Will the patient concurrently take Benlysta with a biologic medication? ❑Yes* ❑No

If YES, specify medication: _____

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Benlysta – FEP MD Fax Form Revised 6/28/2024

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***