Neighborhood Health Plan OF RHODE ISLAND™

Benlysta Authorization form J0490

Tel. 401-427-8200; Fax 844-639-7906

Benlysta Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: ☐ Male ☐Female ☐Unknown Primary Language: ☐ English ☐Spanish ☐ Other:
REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: ______________________________and NPI_________________________

❑ If Buy & Bill: Specify Provider/ Facility: _____________________ and NPI _______________

Servicing Provider Fax#: _____________________

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	☐ Initial Request ☐ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:
ICD 10 Codes:		

Clinical Assessment (provide all required information and clinical documentation)	YES	NO
Is the prescriber a rheumatologist?	☐	☐
Is the patient 18 years of age or older?	☐	☐
Does the patient have severe active lupus nephritis or severe active CNS lupus?	☐	☐
Is the patient receiving Benlysta in combination with other biologics, including B-cell targeted therapies and IV cyclophosphamide?	☐	☐
Does the Patient have hepatic impairment or a CrCl of less than 15 mL/min?	☐	☐
Is the Patient pregnant?	☐	☐
Does the patient have auto-antibody positive systemic lupus erythematosus (SLE) or anti-Smith antibody?	☐	☐
Does the patient have a SELENA-SLEDAI or SLEDAI-2K score of at least 6 or greater, or a SLAM score of at least 7 or greater?	☐	☐

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Does the patient have a positive auto-antibody test result:		
Anti-nuclear antibody (ANA) titer ≥ 1:80; or	☐	☐
Anti-double standard DNA level ≥ 30 IU/mL; or	☐	☐
Anti-Smith antibody?	☐	☐
Does the patient have clinical documentation that the patient is currently taking and adherent to one of the following agents:Glucocorticoids; or Azathioprine; or Leflunomide; or Methotrexate; or Mycophenolate; or Hydroxychloroquine alone or in combination; or Cyclophosphamide (alone) with poor response; or the patient has had failure, intolerance or contraindication to at least two of the above mentioned agents?	☐	☐
Continuation of therapy: Does the patient meet all initial criteria?	☐	☐
Is the patient tolerating therapy?	☐	☐
Has the patient achieved clinical benefit from Benlysta as evidenced by a decrease in his/her SELENA-SLEDAI score?	☐	☐
NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN		

Signature of Requesting Provider:	Date:

Authorization is not a guarantee of payment. Member must be eligible at time of service.