Benlysta

HMSACOM - 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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay 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:** ________________
Patient's Phone Number: _______________________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

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

Additional Demographic Information:

Patient Weight: __________________________*kg*

Patient Height: ____________*ft* ___________*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? __________________

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Criteria Questions:

1. What is the patient's diagnosis?
❒ Active systemic lupus erythematosus (SLE), *Continue to #2*
❒ Active lupus nephritis, *Continue to #2*
❒ Other, *Continue to #2*

2. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to #3*
❒ No, *Continue to #10*

CONTINUATION CRITERIA

3. 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? ***Action Required***: If 'Yes', attach medical records (e.g., chart notes, lab reports) documenting disease stability or improvement
❒ Yes, *Continue to #4*
❒ No, *Continue to #4*

4. Will the patient be using the requested drug in combination with other biologics?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

INITIAL CRITERIA

10. Does the patient have severe active central nervous system (CNS) lupus [including seizures that are attributed to CNS lupus, psychosis, organic brain syndrome, cerebritis, or CNS vasculitis requiring therapeutic intervention before initiation of the requested drug]?
❒ Yes, *Continue to #11*
❒ No, *Continue to #11*

11. Will the patient be using the requested drug in combination with other biologics?
❒ Yes, *Continue to #12*
❒ No, *Continue to #12*

12. What is the patient's diagnosis?
❒ Active systemic lupus erythematosus (SLE), *Continue to #20*
❒ Active lupus nephritis, *Continue to #30*

Systemic lupus erythematosus (SLE)

20. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus (SLE) (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins)? ***Action Required***: If 'Yes', attach medical records (e.g., chart notes, lab reports) documenting the presence of autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins)
❒ Yes, *Continue to #21*
❒ No, *Continue to #21*
❒ Unknown, *Continue to #21*

21. Is the patient currently receiving a standard treatment regimen for systemic lupus erythematosus (SLE) with any of the following (alone or in combination)?

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- Glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone)
- Antimalarials (e.g., hydroxychloroquine)
- Immunosuppressives (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide)

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Active lupus nephritis

30. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus (SLE) (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins) or was lupus nephritis confirmed on kidney biopsy? ***Action Required***: If 'Yes', attach medical records (e.g., chart notes, lab reports) documenting the presence of autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm antiphospholipid antibodies, complement proteins) or kidney biopsy supporting the diagnosis?
❒ Yes, *Continue to # 31*
❒ No, *Continue to # 31*
❒ Unknown, *Continue to # 31*

31. Is the patient current receiving a standard therapy regimen for lupus nephritis (e.g., cyclophosphamide, mycophenolate mofetil, azathioprine, glucocorticoids)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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)**