Please complete ALL information below and fax your request to 1-888-671-5285

Benlysta® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Active systemic lupus erythematosus (SLE)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the patient autoantibody positive (i.e., anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL, antibodies to DNA [Anti-dsDNA], Anti-Smith [Anti-Sm])? ❑ **Yes** ❑ **No**

Is the patient currently receiving at least one standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials [e.g., hydroxychloroquine], corticosteroids, NSAIDs, or immunosuppressants)? ❑ **Yes** ❑ **No**

Is Benlysta prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.