

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Benlysta[®] (belimumab) Subcutaneous Injection (Pharmacy)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Recommended Dosing:

| Diagnosis | Adults (Auto-injector or Prefilled syringe) | Pediatric Patients 5 to less than 18 years of age (Auto-injector only) |
|-----------------|--|--|
| SLE | 200 mg once weekly | <ul style="list-style-type: none"> • Patients ≥ 40 kg: 200 mg once weekly • Patients 15 kg to <40 kg: 200 mg once every 2 weeks |
| Lupus Nephritis | 400 mg once weekly x 4 doses, followed by 200 mg once weekly | <ul style="list-style-type: none"> • Patients ≥ 40 kg: 400 mg once weekly for 4 doses, followed by 200 mg once weekly • Patients 15 kg to <40 kg: 200 mg once weekly for 4 doses, followed by 200 mg once every 2 weeks |

Quantity Limits: 200 mg once weekly (4 injections per 28 days)

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Diagnosis: Active Systemic Lupus Erythematosus (SLE) in patients who are receiving standard therapy

Initial Authorization: 12 months

- ❑ Prescribed by or in consultation with a Rheumatologist
- ❑ Member is 5 years of age or older with a diagnosis of active, autoantibody-positive SLE confirmed by **ONE** of the following (**submit lab results**):
 - ❑ anti-nuclear antibody (ANA) titer \geq 1:80
 - ❑ anti-double stranded DNA (anti-dsDNA) \geq 30 IU/mL
- ❑ Member's SLE activity has been confirmed by **ONE** of the following (**submit results**):
 - ❑ Safety of Estrogen in Lupus National Assessment – Systemic Lupus Erythematosus Disease Activity Index (SELENA-SLEDAI) score of 6-12
 - ❑ \geq 2 British Isles Lupus Assessment Group (BILAG) B organ domain scores
- ❑ Member has tried **three (3)** of the following and is established on **TWO** of the following therapies taken for the last 90 days (**please submit chart notes documenting therapy trials with insufficient disease control**):

| | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> mycophenolate | <input type="checkbox"/> hydroxychloroquine | <input type="checkbox"/> azathioprine |
| <input type="checkbox"/> cyclophosphamide | <input type="checkbox"/> methotrexate | <input type="checkbox"/> cyclosporine |
| <input type="checkbox"/> corticosteroids | <input type="checkbox"/> Other _____ | |

- ❑ Member does **NOT** have any of the following limitations to therapy: severe active central nervous system lupus, current or previous diagnosis of progressive multifocal leukoencephalopathy (PML), or concurrent use with other biologics

❑ Diagnosis: Active Systemic Lupus Erythematosus (SLE) in patients who are receiving standard therapy

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ All initial authorization criteria continues to be met
- ❑ Member's response to therapy has been confirmed by **ONE** of the following (**submit results**):
 - ❑ Safety of Estrogen in Lupus National Assessment – Systemic Lupus Erythematosus Disease Activity Index (SELENA-SLEDAI) score has improved by and/or maintained at a level that is \geq 4 points below baseline score
 - ❑ No new BILAG-A organ domain score OR 2 new BILAG-B organ domain scores

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- Member has an absence of intolerable side effects such as serious infections, signs or symptoms of progressive multifocal leukoencephalopathy (PML), malignancy, severe hypersensitivity reactions/anaphylaxis, or serious infusion reactions

Diagnosis: Active Lupus Nephritis (LN) in patients who are receiving standard therapy

Initial Authorization: 12 months

- Prescribed by or in consultation with a Nephrologist or Rheumatologist
- Member is 5 years of age or older with a diagnosis of active lupus nephritis Class III, IV, or V as confirmed by renal biopsy
- Member's diagnosis of active, autoantibody-positive SLE was confirmed by **ONE** of the following (**submit lab results for documentation**):
 - anti-nuclear antibody (ANA) titer \geq 1:80
 - anti-double stranded DNA (anti-dsDNA) \geq 30 IU/mL
- Member has active renal disease and has received standard therapy for the last 90 days with **ONE** of the following (**chart notes documenting established therapy must be submitted**):
 - mycophenolate
 - calcineurin inhibitor (i.e., cyclosporine, tacrolimus)
 - cyclophosphamide
- Provider must obtain a baseline measurement of **ONE** of the following collected within the last 30 days (**submit lab results**):
 - urine protein:creatinine ratio (uPCR)
 - urine protein
- Member does **NOT** have any of the following limitations to therapy: severe active central nervous system lupus, current or previous diagnosis of progressive multifocal leukoencephalopathy (PML), or concurrent use with other biologics

Diagnosis: Active Lupus Nephritis (LN) in patients who are receiving standard therapy

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- All initial authorization criteria continues to be met
- Member has had improvement from baseline and/or stabilization since last approval of **ONE** of the following (**submit current labs collected within the last 30 days**):
 - urine protein:creatinine ratio (uPCR)
 - urine protein

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- ❑ Member has an absence of intolerable side effects such as serious infections, signs or symptoms of progressive multifocal leukoencephalopathy (PML), malignancy, severe hypersensitivity reactions/anaphylaxis, or serious infusion reactions

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****