

SENTARA COMMUNITY PLAN (MEDICAID)

MEDICAL 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 1-844-305-2331.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed.**

Drug Requested: Benlysta[®] (belimumab) Intravenous Infusion (J0490) (Medical)

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: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Dosage & Administration: Intravenous Administration in Adults with SLE or Lupus Nephritis and Pediatric Patients with SLE –10 mg/kg at 2-week intervals for the first 3 doses and at 4-week intervals thereafter. Reconstitute, dilute, and administer as an intravenous infusion over a period of 1 hour

- Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA/DIAGNOSIS: 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. Check box below for the Diagnosis that applies.

- Diagnosis - active systemic lupus erythematosus (SLE) in patients who are receiving standard therapy**

Initial Authorization: 12 months

(Continued on next page)

- Must be 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 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 lupus nephritis in adults who are receiving standard therapy

Initial Authorization: 12 months

- Must be prescribed by or in consultation with a nephrologist or rheumatologist
- Member is 18 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**):
 - 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 corticosteroids along with one of the following (**chart notes documenting established therapy must be submitted**):
 - mycophenolate
 - cyclophosphamide
- Provider must obtain a baseline measurement of one of the following collected within the last 30 days (**labs must be submitted**):
 - urine protein:creatinine ratio (uPCR)
 - urine protein

(Continued on next page)

- 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

Reauthorization Approval: 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.

Diagnosis - systemic lupus erythematosus (SLE) in adults

- All of the 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 ≥ 4 points below baseline score
 - No new BILAG-A organ domain score OR 2 new BILAG-B organ domain scores
- Member has 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

Reauthorization Approval: 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.

Diagnosis - active lupus nephritis in adults

- All of the 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 completed within the last 30 days**):
 - Urine protein:creatinine ratio (uPCR)
 - Urine protein
- Member has 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 - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

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.