OPTIMA HEALTH PLAN

PHARMACY/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 1-800-750-9692.** 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) **Subcutaneous Injection (Pharmacy)**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

QUANTITY LIMITS: For adults with SLE: Maximum of 200 mg once weekly. For adults with lupus nephritis: 400 mg once weekly for 4 doses, then 200 mg once weekly thereafter

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 adults who are receiving standard therapy**

Initial Authorization: 12 months

- ❑ Must be prescribed by or in consultation with a rheumatologist
- ❑ Member is 18 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 ≥ 1:80
  - ❑ anti-double stranded DNA (anti-dsDNA) ≥ 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
  - ❑ ≥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)**:

❑ mycophenolate	❑ hydroxychloroquine	❑ azathioprine
❑ cyclophosphamide	❑ methotrexate	❑ cyclosporine
❑ corticosteroids	❑ Other_____	

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- ❑ 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 ≥ 1:80
  - ❑ anti-double stranded DNA (anti-dsDNA) ≥ 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
- ❑ 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

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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.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 3/8/2021
REVISED/UPDATED: 6/30/2021