

BENLYSTA

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Dosage:	Frequency:	Qty Dispensed:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of Diagnosis:	
Please indicate place of administration? <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Facility		Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please provide facility/provider name and address:			

MEDICAL HISTORY

Please provide Anti-nuclear anti-body titer (ANA): _____		
Please provide Anti-double standard DNA (dsDNA) level: _____		
Does the member have severe active lupus nephritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have severe active central nervous system lupus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is Benlysta being used in combination with any other therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list below.		
Medication Name	Strength/Frequency	Dates of Therapy
Does the member have evidence of an active infection?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the member tried and failed any of the following medications?		
<input type="checkbox"/> Cellcept (mycopholate)	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Imuran (azathioprine)
<input type="checkbox"/> Plaquenil (hydroxychloroquine)	<input type="checkbox"/> Other (please specify):	

HISTORY OF PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Name	Date of Therapy		Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing
	Start Date	End Date			

Please provide any additional information which should be considered in the space below:
