# 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:** ❑ **Brand** ❑ **Generic** | **Dosage:** | **Frequency:** | **Qty Dispensed:** |

***Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.***

| | | | |
|---|---|---|---|
| ❑ **New medication** ❑ **Ongoing medication** | **If ongoing, provide date started:** | **If medication is ongoing, Did member show improvement while on therapy?** | ❑**Yes** ❑**No** |
| **Diagnosis:** | | **Date of Diagnosis:** | |
| **Please indicate place of administration?** | ❑Physician's Office ❑Hospital/Facility | **Please indicate how medication will be billed:** ❑ Billed directly by the provider via JCODE Provide JCODE:_____ ❑ Billed by a pharmacy and delivered to the provider ❑ 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?** | ❑ **Yes** ❑ **No** |
| **Does the member have severe active central nervous system lupus?** | ❑ **Yes** ❑ **No** |

**Is Benlysta being used in combination with any other therapies?** ❑**Yes** ❑**No** **If yes, please list below.**

| **Medication Name** | **Strength/Frequency** | **Dates of Therapy** |
|---|---|---|
| | | |
| | | |
| | | |

| | |
|---|---|
| **Does the member have evidence of an active infection?** | ❑ **Yes** ❑ **No** |

**Has the member tried and failed any of the following medications?**

| | | |
|---|---|---|
| ❑ **Cellcept (mycopholate)** | ❑ **Methotrexate** | ❑ **Imuran (azathioprine)** |
| ❑ **Plaquenil (hydroxychloroquine)** | ❑ **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:**