Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Benlysta (belimumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Benlysta (belimumab).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the prescriber a Rheumatologist or Nephrologist?
   □ No □ Yes

<u>If prescribed for lupus nephritis (LN) class III, IV, or V:</u>

1. Is the patient 5 years of age or older?
   □ No □ Yes

2. Is disease severity (with or without kidney biopsy) – lupus nephritis class III (focal lupus nephritis), class IV (diffused lupus nephritis), or class V (membranous lupus nephritis)?
   □ No □ Yes

3. Is eGFR ≥ 30 mL/min/1.73m^2?
   □ No □ Yes

4. Is patient pregnant?
   □ No □ Yes

5. Does the patient have prior use of dialysis in the past 12 months?
   □ No □ Yes

6. Is the patient currently using with Lupkynis (voclosporin)?
   □ No □ Yes

7. Is the patient currently receiving standard of care therapy with one or more of the following: cyclophosphamide, mycophenolate, azathioprine, calcineurin inhibitor, or corticosteroid?
   □ No □ Yes

<u>If prescribed for systemic lupus erythematosus (SLE):</u>

1. Is the patient 18 years or older (cutoff for subcutaneous Benlysta; IV Benlysta is indicated for 5 years of age or older)?
   □ No □ Yes

2. Is the patient autoantibody-positive SLE (antinuclear antibody titers ≥1:80, anti-double stranded DNA antibodies or both) OR biopsy proven SLE by kidney OR anti-double stranded DNA positive lupus with a history of hypocomplementemia?
   □ No □ Yes

3. Does the patient have severe active central nervous system lupus?
   □ No □ Yes

4. Will Benlysta be used in combination with biologics (e.g., rituximab)?
   □ No □ Yes

5. Is patient on concomitant standard-of-care with hydroxychloroquine, unless contraindicated or intolerant?
   □ No □ Yes

6. Does patient have history of contraindication, intolerance, or inadequate clinical response to at least one of the following: corticosteroid, methotrexate, or mycophenolate?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Is there physician documentation of disease stability and improvement within the last 12 months?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**