

**Benlysta (Non-PDL)**

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Patient Name:		Prescriber Name:	
HPP HPP Member Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Patient Primary Phone:		NPI:	PA PROMISe ID:
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP		Specialty Pharmacy (if applicable):	
Drug Name:		Strength:	
Quantity:		Refills:	
Directions:			
Diagnosis Code:		Diagnosis:	
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. Is the request for reauthorization of Benlysta?

Yes

No

Q2. Is the patient 5 years or older?

Yes

No

Q3. Is the medication prescribed by or in consultation with an appropriate specialist, such as a rheumatologist or nephrologist?

Yes

No

Q4. Does the patient have a diagnosis of systemic lupus erythematosus (SLE) or active lupus nephritis (LN) with documentation attached confirming diagnosis?

Yes

No

Q5. Does the patient have a therapeutic failure, contraindication or intolerance to standard therapy (at least one: for SLE: hydroxychloroquine, mycophenolate, azathioprine; for LN: mycophenolate, IV or oral cyclophosphamide, azathioprine, oral glucocorticoid) OR being transitioned from Benlysta Intravenous administration to Benlysta subcutaneous injection?

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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is the patient currently being treated for any active infection?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Does the patient tolerate the medication without side effects?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is there documentation showing a positive clinical response to Benlysta?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2024