OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 1-844-348-3720.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

Drug Requested: Benlysta® (Blimumab) **IV (J-0490) (Medical)**

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength/Month: ____

Dosing Schedule: ______________________________ **Length of Therapy:** ____________

Diagnosis: ______________________________ **ICD Code**: ____________

****Medical notes MUST be submitted to support each line checked on this request.****

CLINICAL CRITERIA: ALL boxes that apply **MUST** be checked to qualify for Benlysta®. Medical documentation **MUST** be attached to this request to ensure authorization will **NOT** be delayed**.**

- Diagnosis of Systemic Lupus Erythematosus ❑ YES ❑ NO
- Member is autoantibody (e.g. ANA, anti-ds-DNA, anti-SM) positive ❑ YES ❑ NO
- Prescribed in combination with standard therapy: corticosteroids, immunosuppressive/cytotoxic agents, antimalarials ❑ YES ❑ NO

MEDICATION BEING PROVIDED BY (check applicable box below):

❑ **Location/site of drug administration:** ____________________________________

NPI or DEA # of administering location: ____________________________________

OR

❑ **Specialty Pharmacy - PropriumRx**

*****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 #: ____

REVISED/UPDATED: ~~12/27/2017; 5/25/2018; 8/16/2018;~~ **10/8/2018**