

OPTIMA HEALTH 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 1-844-723-2094.** 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 #: _____