# OPTIMA HEALTH COMMUNITY CARE
# AND
# OPTIMA HEALTH FAMILY CARE
# (MEDICAID)

## PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

**Drug Requested: Benlysta®** (belimumab) **SQ (Pharmacy Only)**

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

**Drug Form/Strength:** ______________________________________________

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

**Diagnosis:** _________________________________ **ICD Code, if applicable**: ___________

**Benlysta® SubQ: –** 200 mg/mL once weekly, single-dose prefilled autoinjector or single-dose prefilled syringe

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

**CLINICAL CRITERIA:** Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

- Member has diagnosis of Systemic Lupus Erythematosus (SLE) ❑ YES ❑ NO
- Member is autoantibody (e.g. ANA, anti-ds-DNA, anti-SM) positive ❑ YES ❑ NO
- Member tried and failed **all three (3)** of the **standard therapies below within the last 18 months (paid pharmacy claims MUST be verified)** ❑ YES ❑ NO

| • corticosteroids | • immunosuppressive/cytotoxic agents | • antimalarials |
|---|---|---|

**Medication being provided by (check applicable box below):**

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

**(Continued on next page; signature page MUST be attached to this request form.)**

**(Signature page MUST be included with request)**

*****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 #:** ______________________________________________

***Approved by Pharmacy and Therapeutics Committee**: 7/21/2011
**REVISED/UPDATED: 5/11/2019**;