

OPTIMA HEALTH COMMUNITY CARE

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. If incomplete, 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 applicable boxes below MUST be checked to qualify for Benlysta®. Medical documentation MUST be attached to this request or authorization process will 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):

Physician's office **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 #: _____