OPTIMA HEALTH PLAN

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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 1-844-202-5034. 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 all 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 below that apply MUST be checked to qualify for Benlysta®. Medical documentation MUST be attached to this request to ensure authorization will NOT be delayed.

- 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):

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

NPI or DEA # of administering location: ______________________________

OR

❑ **Specialty Pharmacy: Briova SpecialtyRx**

*****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**: 7/21/11
REVISED/UPDATED: ~~7/20/2011; 8/15/2011; 4/2/2012;~~ 4/19/2012; ~~8/8/2014; 10/31/2014; 4/3/2015; 5/23/2015; 12/30/2015; 1/29/2016; 8/17/2016; 9/22/2016; 12/11/2016; 7/24/2017;~~ 12/7/2017; ~~3/28/2018;~~ **7/10/2018**