US Family Health Plan
Prior Authorization Request Form for
belimumab (**Benlysta**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization will expire in 1 year. For renewal of therapy an initial Tricare/USFHP prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient taking concomitant biologics (for example rituximab) and/or intravenous cyclophosphamide?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 2**
2. Does the patient have severe active lupus nephritis or severe active central nervous system lupus?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 3**
3. Is the patient concurrently taking standard therapy for SLE (for example hydroxychloroquine, systemic corticosteroid and/or immunosuppressives either alone or in combination)?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Benlysta*	☐ Yes **Proceed to question 8**	☐ No **Proceed to question 5**
5. Is the patient GREATER THAN or EQUAL to 5 years of age?	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a documented diagnosis of active, autoantibody positive (that is positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]) systemic lupus erythematosus (SLE)?	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**

7. Is the requested medication being prescribed by or consultation with a specialty provider for systemic lupus erythematosus (SLE): rheumatologist, cardiologist, neurologist, nephrologist, immunologist, or dermatologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
8. Has treatment with Benlysta shown documented clinical benefit (that is improvement in number/frequency of flares, improvement in in Safety of Estrogen in Lupus Erythematosus National Assessment - SLE Disease Activity Index (SELENA-modified SLEDAI) score, improvement/stabilization of organ dysfunction, improvement in complement levels/lymphocytopenia, etc.)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____