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 855-273-5735

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 2 years. For renewal of therapy an initial USFHP prior authorization approval is required and will be approved on a yearly basis.

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. Does the patient have severe active central nervous system lupus?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 2**
2. Is the patient taking concomitant biologics (for example rituximab)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 3**
3. What is the indication or diagnosis?	☐ Active, autoantibody positive (that is positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]) systemic lupus erythematosus (SLE) - **Proceed to question 4** ☐ Class III, IV, or V active lupus nephritis - **Proceed to question 7** ☐ Other – **STOP Coverage not approved**	
4. 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 5**	☐ No **STOP** **Coverage not approved**
5. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Benlysta.*	☐ Yes **Proceed to question 6**	☐ No **Proceed to question 9**

6. 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**
7. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a approved PA for Benlysta.*	☐ Yes **Sign and date below**	☐ No **Proceed to question 8**
8. Is the patient concurrently receiving mycophenolate mofetil, cyclophosphamide or azathioprine?	☐ Yes **Proceed to question 10**	☐ No **STOP** **Coverage not approved**
9. Is the patient greater than or equal to 5 years of age?	☐ Yes **Proceed to question 11**	☐ No **STOP** **Coverage not approved**
10. Is the patient greater than or equal to 18 years of age?	☐ Yes **Proceed to question 11**	☐ No **STOP** **Coverage not approved**
11. Is the requested medication being prescribed by or in consultation with a specialty provider: rheumatologist, cardiologist, neurologist, nephrologist, immunologist, or dermatologist?	☐ 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 _____