Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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Montana Healthcare Programs Prior Authorization Request Form for Use of Subcutaneous Benlysta (belimumab)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty:	Prescriber Fax:	
Requested Dose/Directions:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ **INITIATION OF THERAPY: Provider attests to the following:**

1. Member has a diagnosis of active, systemic lupus erythematosus (SLE) of the mucocutaneous and/or musculoskeletal organ system: ☐ Yes ☐ No
2. Member has a history of positive anti-nuclear antibody (ANA ≥ 1:80): Result:_____ Date:_____
3. Member has experienced functional impairment due to poor SLE control. Please check all that apply:
   - ☐ Limitation of activities of daily living due to pain
   - ☐ Impaired ambulation
   - ☐ Work or school absences
   - ☐ Other: _____
4. Member is currently on therapy for SLE: ☐ Yes ☐ No AND *all of the following have been met:*
   a. Member requires daily use of oral corticosteroids: ☐ Yes ☐ Not tried ☐ Ineffective/contraindicated/not tolerated
   b. Previous treatment courses of *at least 12 weeks each* of **2** or more of the following have been ineffective or not tolerated:

☐ Chloroquine	Dates: _____	Result: _____
☐ Hydroxychloroquine	Dates:_____	Result:_____
☐ Methotrexate	Dates:_____	Result:_____
☐ Azathioprine	Dates:_____	Result:_____
☐ Cyclophosphamide	Dates:_____	Result:_____
☐ Mycophenolate mofetil	Dates:_____	Result:_____

   c. Member is not currently on IV cyclophosphamide: ☐ Yes ☐ No

LIMITATIONS: 4 x 200 mg autoinjectors/pre-filled syringes per 28 days.

Initial approval will be issued for 6 months.

☐ **CONTINUATION OF THERAPY:**

Documentation is attached supporting positive response to therapy as demonstrated by any of the following:

a. Reduction in required daily dose of oral corticosteroids: ☐ Yes ☐ No
b. Documented improvement in functional impairment: ☐ Yes ☐ No
c. Decrease in number of exacerbations: ☐ Yes ☐ No

Reauthorization will be issued for 6 months.

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit at 1-800-294-1350