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

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
<td>Prescriber Phone:</td>
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<tr>
<td>Prescriber Name/Specialty:</td>
<td>Prescriber Fax:</td>
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<td>Requested Dose/Directions:</td>
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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

01/2020