

Benlysta (belimumab)

Fax completed form to: (855) 840-1678 If this is an URGENT request, please call (800) 882-4462

PHYSICIAN INFORMATION			PATIENT INFORMATION				
* Physician Name: Specialty:	* DEA, NPI or TIN:		*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*				
Office Contact Person:			* Patient Name:				
Office Phone:			* Cigna ID:		* Date of Birth:		
Office Fax:			* Patient Street Address:				
Office Street Address:			City:	State:	itate: Zip:		
City:	State:	Zip:	Patient Phone:				
Urgency: Standard Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)							
Medication requested: Benlysta 120mg vial Benlysta 400mg vial Benlysta 200mg/ml auto injector Benlysta 200mg/ml syringe							
ICD10:							
Directions for use: Quantity:			Duration of therapy: J-Code:				
Is this for new start of therapy or continuation of therapy? If your patient has already begun treatment with drug samples of this drug, please choose "new start of therapy".							
(if continuation of therapy) Is there documentation of a beneficial response to this medication? Examples of a response to therapy include: reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, improvement in specific organ dysfunction [for example, musculoskeletal, blood, hematologic, vascular, and others] Yes \Box No \Box							
Where will this medication be obtained? Accredo Specialty Pharmacy** Hospital Outpatient Retail pharmacy Other (please specify):			 Home Health / Home Infusion vendor Physician's office stock (billing on a medical claim form) **Cigna's nationally preferred specialty pharmacy 				
**Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557							
Facility and/or doctor dispensing and administering medication: Facility Name: State: Address (City, State, Zip Code):							
Where will this drug be a Patient's Home Hospital Outpatient	Physician's OfficeOther (please specify):						
NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting. Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? Yes No (provide medical necessity rationale):							
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient?							

Diagnosis: Lupus Nephritis (LN) Rheumatoid Arthritis Severe active central nervous system lupus systemic lupus erythematosus (SLE) Other (please specify): Clinical Information:							
Will your patient be treated with any other biological therapies while taking the requested medication?	☐ Yes ☐ No ☐ Yes ☐ No						
Is the requested medication being used concurrently with Lupkynis (voclosporin capsules)?							
If LN							
Does the patient have biopsy-confirmed lupus nephritis (WHO class III, IV, or V)?	🗌 Yes 🗌 No						
Will your patient be treated concurrently (at the same time) with at least ONE standard therapy such as: azathioprine (generic for Imuran), mycophenolate mofetil (generic for CellCept), or cyclophosphamide (generic for Cytoxan or Neosar)? Yes 🗌 No [
(if no or unknown) Is your patient intolerant (due to significant toxicity, as determined by the prescribing physician) to at least standard therapy such as: azathioprine (generic for Imuran), mycophenolate mofetil (generic for CellCept), or cyclophosphat (generic for Cytoxan or Neosar)?							
(if LN) Was this medication prescribed by, or in consultation with, a nephrologist or rheumatologist?	Yes 🗌 No 🗌						
If SLE							
Has the patient tested positive for Systemic Lupus Erythematosus (SLE) autoantibodies (defined as positive for antir [ANA] and/or anti-double-stranded DNA [anti-dsDNA] antibody)?	uclear antibodies Yes 🗌 No 🗌						
 Will your patient be treated concurrently (at the same time) with at least one of the following? A) hydroxychloroquine (Plaquenil); B) an immunosuppressant agent (like oral cyclophosphamide, azathioprine [generic Imuran], mycophenolate mofetil Myfortic], methotrexate [mtx], or cyclosporine [Sandimmune, Neoral]); C) corticosteroids (like methylprednisolone, prednisone)? 	[generic Cellcept, Yes □ No □						
(if no) Is your patient intolerant (due to significant toxicity, as determined by the prescribing physician) to at least ONE of the							
 A) hydroxychloroquine; B) immunosupressant agents (for example, oral cyclophosphamide, azathioprine [Imuran], mycophenolate [Cellcept, methotrexate [MTX], or cyclosporine [Sandimmune, Neoral]); or C) corticosteroids (for example, methylprednisolone, prednisone)? 	-						
(if SLE) Was this medication prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologis dermatologist?							
Additional pertinent information (including any clinical rationale for the use of this drug):							
Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.							
Prescriber Signature: Date:							
Save Time! Submit Online at: <u>www.covermymeds.com/main/prior-authorization-forms/cigna/</u> or via SureScr	ipts in your EHR.						
Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.							
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