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

Benlysta
(belimumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*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.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	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

(if IV injection) What is your patient's current weight? : 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". ☐ new start of therapy ☐ continued therapy

(if continued therapy) Which applies to your patient?
☐ patient is established on this drug with previous approval by Cigna
☐ patient is established on this drug with previous approval by another health plan
☐ patient is established on this drug with regular use for more than 1 year
☐ patient was previously established on this drug, and is restarting after a break in therapy
Please provide the dates your patient has received **Benlysta**:

(if continued therapy) Has your patient had a good response to therapy with this drug? Yes ☐ No ☐

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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: Tax ID#:
Address (City, State, Zip Code):
Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes ☐ No ☐
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

Where will this medication be administered?

☐ Patient's Home
☐ Physician's Office
☐ Hospital Inpatient ***
☐ Hospital Outpatient ***
☐ Ambulatory Infusion Center ***

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? ☐ Yes ☐ No

Diagnosis:

☐ Lupus Nephritis (LN)
☐ systemic lupus erythematosus (SLE)
☐ Other (please specify):

Clinical Information:

If LN

Has the patient tested positive for Systemic Lupus Erythematosus (SLE) autoantibodies (defined as positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA [anti-dsDNA] antibody)? 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 ONE standard therapy such as: azathioprine (generic for Imuran), mycophenolate mofetil (generic for CellCept), or cyclophosphamide (generic for Cytoxan or Neosar)? Yes ☐ No ☐

(if LN) Was this drug prescribed by, or in consultation with, a nephrologist or rheumatologist? Yes ☐ No ☐

If SLE

Did your patient have a positive autoantibody test as shown by either of the following?

☐ ANA (anti-nuclear antibody) greater than or equal to 1:80
☐ anti-dsDNA (anti-double-stranded DNA) greater than or equal to 30 IU/ml
☐ neither of the above

Did your patient have failure or inadequate response to any of the following?

☐ hydroxychloroquine (generic Plaquenil)
☐ any of the following immunosuppressant agents: oral cyclophosphamide, azathioprine (Imuran), mycophenolate mofetil (Cellcept, Myfortic), methotrexate (mtx), or cyclosporine (Sandimmune, Neoral
☐ corticosteroids (methylprednisolone, prednisone)
☐ none of the above

Will your patient be treated with any other biological therapies for SLE (for example, tumor necrosis factor inhibitors)? Yes ☐ No ☐
(if yes) Please provide details, including drug name(s).

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 [generic Cellcept, Myfortic], methotrexate [mtx], or cyclosporine [Sandimmune, Neoral]);
C) corticosteroids (like methylprednisolone, prednisone)? Yes ☐ No ☐

(if no) Is your patient intolerant (due to significant toxicity, as determined by the prescribing physician) to at least ONE of the following:
A) hydroxychloroquine;
B) immunosupressant agents (for example, oral cyclophosphamide, azathioprine [Imuran], mycophenolate [Cellcept, Myfortic], methotrexate [MTX], or cyclosporine [Sandimmune, Neoral]); or
C) corticosteroids (for example, methylprednisolone, prednisone)? Yes ☐ No ☐

(if SLE) Was this drug prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist? Yes ☐ No ☐

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:**_____

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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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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005