



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Benlysta 120mg vial <input type="checkbox"/> Benlysta 400mg vial <input type="checkbox"/> Benlysta 200mg/ml auto injector <input type="checkbox"/> 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". <input type="checkbox"/> new start of therapy <input type="checkbox"/> continued therapy (if continued therapy) Which applies to your patient? <input type="checkbox"/> patient is established on this drug with previous approval by Cigna <input type="checkbox"/> patient is established on this drug with previous approval by another health plan <input type="checkbox"/> patient is established on this drug with regular use for more than 1 year <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): **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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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:

- ☐ systemic lupus erythematosus (SLE) ☐ Other (please specify):

Clinical Information:

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) immunosuppressant 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 ☐

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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