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

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

ICD10:

Directions for use: Quantity: Duration of therapy: J-Code:
Dose (in Mg/kg): Frequency (for example Weeks 0, 2):

Will the dose be administered at Weeks 0, 2, and 4, with subsequent doses separated by at least 4 weeks? Yes ☐ No ☐

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: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (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? ☐ Yes ☐ No

Diagnosis:
☐ Lupus Nephritis (LN)
☐ Rheumatoid Arthritis
☐ Systemic Lupus Erythematosus (SLE)
☐ Other: (Please provide the patient's diagnosis or reason for treatment):

Clinical Information:

Will the requested medication be used in combination with another biologic agent (for example, Cimzia, an etanercept product [Enbrel, biosimilars], an adalimumab product [Humira, biosimilars], Saphnelo, Simponi [Aria or SC], an infliximab product [Remicade, biosimilars], Actemra [SC or IV], Kevzara, Orencia [SC or IV], a rituximab product [Rituxan, biosimilars], Kineret, Stelara [SC or IV], Siliq, Cosentyx, Taltz, Ilumya, Tremfya, Skyrizi, Entyvio, Zymfentra, Omvoh, and Bimzelx)? ☐ Yes ☐ No

Is the requested medication being used in combination with Lupkynis (voclosporin capsules)? ☐ Yes ☐ No

If LN
Is this medication being prescribed by, or in consultation with, a nephrologist or rheumatologist? ☐ Yes ☐ No

Is the requested medication being used concurrently with an immunosuppressive regimen? Note: Examples of an immunosuppressive regimen include azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate mofetil, and/or a systemic corticosteroid. ☐ Yes ☐ No

Is the patient currently receiving Benlysta intravenous or subcutaneous? ☐ Yes ☐ No

(if no) Has the diagnosis of lupus nephritis been confirmed on biopsy? Please Note: For example, World Health Organization class III, IV, or V lupus nephritis. ☐ Yes ☐ No

(if yes) According to the prescriber, has the patient responded to Benlysta subcutaneous or intravenous? Please Note: Examples of a response include improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, and improvement in complement levels (that is, C3, C4). ☐ Yes ☐ No

If SLE
Is this medication being prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist? ☐ Yes ☐ No

Is the requested medication being used concurrently with at least ONE other standard therapy for systemic lupus erythematosus (SLE)? Note: Examples of standard therapies include an antimalarial (for example, hydroxychloroquine), systemic corticosteroid (for example, prednisone), and other immunosuppressants (for example, azathioprine, mycophenolate mofetil, methotrexate). ☐ Yes ☐ No

(if no) According to the prescriber, is the patient intolerant to standard therapy due to a significant toxicity? ☐ Yes ☐ No

Is the patient currently receiving Benlysta intravenous or subcutaneous? ☐ Yes ☐ No

(if no) Does the patient have autoantibody-positive systemic lupus erythematosus (SLE), defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA (anti-dsDNA) antibody? Note: Not all patients with SLE are positive for anti-dsDNA, but most will be positive for ANA. ☐ Yes ☐ No

(if yes) According to the prescriber, has the patient responded to Benlysta subcutaneous or intravenous? Please Note: Examples of a response include reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, improvement in complement levels (that is, C3, C4), or improvement in specific organ dysfunction (for example, musculoskeletal, blood, hematologic, vascular, others). ☐ Yes ☐ No

Additional pertinent information: *Please provide any additional pertinent clinical information*

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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