Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Benlysta

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for a renewal?

☐ Yes ☐ No

Q2. Is the request for Benlysta injection for subcutaneous use?

☐ Yes ☐ No

Q3. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q4. Is the request for Benlysta intravenous infusion?

☐ Yes ☐ No

Q5. Is the patient 5 years or older?

☐ Yes ☐ No

Q6. Is the medication prescribed by or in consultation with an appropriate specialist, such as a rheumatologist?

☐ Yes ☐ No

Q7. Does the patient have a diagnosis of systemic lupus erythematosus (SLE) or active lupus nephritis (LN) with documentation attached confirming diagnosis?

☐ Yes ☐ No

Q8. Does the patient have a therapeutic failure, contraindication or intolerance to standard therapy (at least one: for

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Patient Name:	Prescriber Name:

SLE: hydroxychloroquine, mycophenolate, azathioprine; for LN: mycophenolate, IV or oral cyclophosphamide, azathioprine, oral glucocorticoid) OR being transitioned from Benlysta Intravenous administration?

☐ Yes ☐ No

Q9. Is the patient currently being treated for any active infection?

☐ Yes ☐ No

Q10. Does the patient tolerate the medication without side effects?

☐ Yes ☐ No

Q11. Does the patient have any active infection?

☐ Yes ☐ No

Q12. Is there documentation showing a positive clinical response to Benlysta?

☐ Yes ☐ No

Q13. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023