



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

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 PROMSe ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	
Quantity:	Refills:	
Directions:		
Diagnosis Code:	Diagnosis:	
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>		

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q2. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q3. Is the medication prescribed by or in consultation with an appropriate specialist, such as a rheumatologist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q4. Does the patient have a diagnosis of systemic lupus erythematosus (SLE) or active lupus nephritis with documentation attached confirming diagnosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q5. Does the patient have a therapeutic failure, contraindication or intolerance to standard therapy (at least one: hydroxychloroquine, mycophenolate, azathioprine) OR being transitioned from Benlysta Intravenous administration?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is the patient currently being treated for any active infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Does the patient tolerate the medication without side effects?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Patient Name:	Prescriber Name:
Q8. Does the patient have any active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is there documentation showing a positive clinical response to Benlysta? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Additional Information:	
Q11. Requested Duration: <input type="checkbox"/> 12 Months	

Prescriber Signature

Date

Updated for 2022