

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:		110111101		
	Diagnosia			
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	es			
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 co	onsultation with	h an appropriate specialist, s	uch as a rheumatologist?	
☐ Yes ☐ No				
Q7. Does the patient have a diagnosis of sy documentation attached confirming diagnos		erythematosus (SLE) or activ	ve lupus nephritis (LN) with	
☐Yes		□ No		
Q8. Does the patient have a therapeutic fail	lure, contraind	lication or intolerance to stan	dard therapy (at least one: for	

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Patient Name:	Prescriber Name:		
SLE: hydroxychloroquine, mycophenolate, azathioprin azathioprine, oral glucocorticoid) OR being transitione	ne; for LN: mycophenolate, IV or oral cyclophosphamide, ed from Benlysta Intravenous administration?		
☐ Yes	□ No		
Q9. Is the patient currently being treated for any active	e 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	al response to Benlysta?		
☐ Yes	□ No		
Q13. Additional Information:			
Q14. Requested Duration:			
☐ 12 Months			
Prescriber Signature	 Date		

Updated for 2022