## Health Partners •••• Medicare

## PRIOR AUTHORIZATION REQUEST FORM

Benlysta - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

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:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business:   Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):
REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I the life or health of the enrollee or the enrollee's ability to regain maximum funct Drug Name:	certify that applying the 72 hour standard review timeframe may seriously jeopardize ion.
Strength:	
Directions / SIG:	
	os and information for this member that may support approval.
	lowing questions and sign.
Q1. Is the request for Benlysta injection for subcutaneous	
☐ Yes	□ No
Q2. Is the patient greater than or equal to 18 years of age	9?
☐ Yes	□ No
Q3. Is the request for Benlysta intravenous infusion?	
☐ Yes	□ No
Q4. Is the patient 5 years or older?	
☐ Yes	□ No
Q5. Is Benlysta prescribed by or in consultation with an a	ppropriate specialist, such as a rheumatologist?
☐ Yes	□ No
Q6. Does the patient have a diagnosis of systemic lupus documentation attached confirming diagnosis?	erythematosus (SLE) or active lupus nephritis (LN) with
☐ Yes	□ No
	lication or intolerance to at least 1 standard therapy (for SLE: mycophenolate, IV or oral cyclophosphamide, azathioprine,
Yes	□ No

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1 = 2.10 = 1.0 1 = 1.10 months (patient, precession, arag, tabe, for status, megiste, or not attached the control precession		
Patient Name:	Prescriber Name:	
Q8. Is the patient currently being treated for any	active infection?	
☐ Yes	□ No	
Q9. Requested Duration:		
☐ 12 months		
Q10. Additional Information:		
Prescriber Signature	Date	
	2023 Medicare Prior Authori	zation Request