

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Lupus Medications-BENLYSTA



Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

Clinical Information

Initial authorization (answer questions 1-7)

1. Does the beneficiary have a diagnosis of active systemic lupus erythematosus (SLE)? Yes No
2. Does the beneficiary have a diagnosis of Lupus Nephritis? Yes No
3. Is the medication being prescribed by or in consultation with a rheumatologist? Yes No
4. Is the beneficiary auto-antibody positive? Yes No
5. Is the beneficiary utilizing the medicine in combination with standard treatment regimens (NSAIDs, corticosteroids, anti-malarials, or immunosuppressive drugs) or standard treatment regimens were not tolerated or beneficial?
 Yes No
6. Does the beneficiary have a diagnosis of severe active lupus nephritis or severe active central nervous system lupus? Yes No
7. Is the medication being used concurrently with other biologics and/or IV cyclophosphamide? Yes No

For re-authorization (answer question 8)

8. Is there documented improvement in functional impairment such as fewer flares that required steroid treatment, lower average daily oral prednisone dose, improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits, or sustained improvement in laboratory measures of lupus activity? Yes No

****Please attach current progress notes documenting disease status and clinical response to the medicine.****

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505

DHB Pharmacy 61
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