Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462

Benlysta
(belimumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Benlysta 120mg vial ☐ Benlysta 400mg vial

ICD10:

Directions for use: Quantity: Duration of therapy: J-Code:
Dose (in Mg/kg): Frequency (for example Weeks 0, 2):

Will the dose be administered at Weeks 0, 2, and 4, with subsequent doses separated by at least 4 weeks? Yes ☐ No ☐

Describe the medication's current place in therapy for this patient. If patient has been taking samples, please pick "Initial Therapy".

☐ Initial Therapy
☐ Patient is currently receiving Benlysta

(if LN and currently receiving Benlysta) Has the patient responded to Benlysta subcutaneous or intravenous, as determined by the prescriber? Note: Examples of a response include improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, and improvement in complement levels (that is, C3, C4). Yes ☐ No ☐

(if SLE and currently receiving Benlysta) Has the patient responded to Benlysta subcutaneous or intravenous, as determined by the prescriber? Note: Examples of a response include reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, improvement in complement levels (that is, C3, C4), or improvement in specific organ dysfunction (for example, musculoskeletal, blood, hematologic, vascular, others). Yes ☐ No ☐

(if no to either of the 2 previous questions) Please provide clinical support for the continued use.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis:

☐ Lupus Nephritis (LN)
☐ Rheumatoid Arthritis
☐ Systemic Lupus Erythematosus (SLE)
☐ Other: (Please provide the patient's diagnosis or reason for treatment):

Clinical Information:

Besides the drug being requested, other biologics include Actemra, adalimumab (Humira and all biosimilars), Adbry, Bimzelx, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, infliximab (Remicade and all biosimilars), Kevzara, Kineret, Litfulo, Olumiant, Omvoh, Orencia, Otezla, Rinvoq, rituximab (Rituxan and all biosimilars), Siliq, Simponi Aria, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tysabri, Velsipity, Xeljanz, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic at this time, nor will they in the future. The requested drug is the only biologic the patient is/will be using.
☐ The patient is currently on another biologic, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biologic.
☐ Other/unknown

(if taking both drugs, other, unknown) Please provide the rationale for concurrent use.

Is the requested medication being used concurrently with Lupkynis (voclosporin capsules)? ☐ Yes ☐ No

(if yes) Please provide the rationale for concurrent use.

If LN

Does the patient have biopsy-confirmed lupus nephritis (WHO class III, IV, or V)? ☐ Yes ☐ No

Is the requested medication being used concurrently with an immunosuppressive regimen? Note: Examples of an immunosuppressive regimen include azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate mofetil, and/or a systemic corticosteroid. ☐ Yes ☐ No

Was this medication prescribed by, or in consultation with, a nephrologist or rheumatologist? Yes ☐ No ☐

If SLE

Does the patient have autoantibody-positive systemic lupus erythematosus (SLE), defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA (anti-dsDNA) antibody? Note: Not all patients with SLE are positive for anti-dsDNA, but most will be positive for ANA. Yes ☐ No ☐

Is the requested medication being used concurrently with at least ONE other standard therapy?
Note: Examples of standard therapies include an antimalarial (for example, hydroxychloroquine), systemic corticosteroid (for example, prednisone), and other immunosuppressants (for example, azathioprine, mycophenolate mofetil, methotrexate). Yes ☐ No ☐

((if no) Is your patient intolerant to standard therapy due to a significant toxicity, as determined by the prescriber? Note: Examples of standard therapies include an antimalarial (for example, hydroxychloroquine), systemic corticosteroid (for example, prednisone), and other immunosuppressants (for example, azathioprine, mycophenolate mofetil, methotrexate). Yes ☐ No ☐

(if SLE) Was this medication prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist? Yes ☐ No ☐

Additional pertinent information *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (samples, out of pocket, etc.).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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