



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.  
Benlysta (belimumab) Prior Authorization (PA)  
Pharmacy Benefits Prior Authorization Help Desk  
Length of Authorizations: Initial- 6 months; Continuation- 12 months

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Benlysta (belimumab)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Prescriber Information**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ NPI: \_\_\_\_\_  
Prescriber Address: \_\_\_\_\_  
Prescriber Phone #: \_\_\_\_\_ Prescriber Fax #: \_\_\_\_\_  
Do you have an approved provider referral number from Kaiser Permanente?  
 Yes – please provide your provider referral number here: \_\_\_\_\_

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_  
Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_  
Sig: \_\_\_\_\_  
Drug 2: Name/Strength/Formulation: \_\_\_\_\_  
Sig: \_\_\_\_\_

## 5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?  
 Initial therapy                       Continuing therapy, state start date: \_\_\_\_\_
2. Indicate the patient's diagnosis for the requested medication: \_\_\_\_\_

### Clinical Criteria:

1. Is the prescriber a Rheumatologist or Nephrologist?  
 No  Yes

### If prescribed for lupus nephritis (LN) class III, IV, or V:

1. Is the patient 5 years of age or older?  
 No  Yes
2. Is disease severity (with or without kidney biopsy) – lupus nephritis class III (focal lupus nephritis), class IV (diffused lupus nephritis), or class V (membranous lupus nephritis)?  
 No  Yes
3. Is eGFR  $\geq 30$  mL/min/1.73m<sup>2</sup>?  
 No  Yes
4. Is patient pregnant?  
 No  Yes
5. Does the patient have prior use of dialysis in the past 12 months?  
 No  Yes
6. Is the patient currently using with Lupkynis (voclosporin)?  
 No  Yes
7. Is the patient currently receiving standard of care therapy with one or more of the following: cyclophosphamide, mycophenolate, azathioprine, calcineurin inhibitor, or corticosteroid?  
 No  Yes

### If prescribed for systemic lupus erythematosus (SLE):

1. Is the patient 18 years or older (cutoff for subcutaneous Benlysta; IV Benlysta is indicated for 5 years of age or older)?  
 No  Yes
2. Is the patient autoantibody-positive SLE (antinuclear antibody titers  $\geq 1:80$ , anti-double stranded DNA antibodies or both) OR biopsy proven SLE by kidney OR anti-double stranded DNA positive lupus with a history of hypocomplementemia?  
 No  Yes
3. Does the patient have severe active central nervous system lupus?  
 No  Yes
4. Will Benlysta be used in combination with biologics (e.g., rituximab)?  
 No  Yes

5. Is patient on concomitant standard-of-care with hydroxychloroquine, unless contraindicated or intolerant?  
 No  Yes

6. Does patient have history of contraindication, intolerance, or inadequate clinical response to at least one of the following: corticosteroid, methotrexate, or mycophenolate?  
 No  Yes

**For continuation of therapy, please respond to additional questions below:**

1. Is there physician documentation of disease stability and improvement within the last 12 months?  
 No  Yes

**6 – Prescriber Sign-Off**

**Additional Information –**

- Please submit chart notes/medical records for the patient that are applicable to this request.**
- If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

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**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

<b>Prescriber Signature:</b>	<b>Date:</b>
<small>Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility</small>	