Prescriber Criteria Form

Benlysta 2026 PA Fax 862-A v1 010126.docx
Benlysta (belimumab)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Benlysta (belimumab).

Drug Name:
Benlysta (belimumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of active systemic lupus erythematosus (SLE)? [If no, then skip to question 6.]	Yes	No
2	Does the patient meet either of the following criteria: A) patient is currently receiving a standard therapy regimen for systemic lupus erythematosus (SLE) (for example, corticosteroid, antimalarial, or NSAIDs), B) patient has experienced an intolerance or has a contraindication to standard therapy regimens for SLE? [If no, then no further questions.]	Yes	No
3	Is the patient new to therapy with the requested drug? [If no, then skip to question 11.]	Yes	No
4	Does the patient have severe active central nervous system lupus? [If yes, then no further questions.]	Yes	No
5	Does the patient have confirmed diagnosis of systemic lupus erythematosus (SLE) from positive autoantibodies relevant to SLE (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins)? [If yes, then skip to question 11.] [If no, then no further questions.]	Yes	No

6	Does the patient have a diagnosis of active lupus nephritis? [If no, then no further questions.]	Yes	No
7	Does the patient meet either of the following criteria: A) patient is currently receiving a standard therapy regimen for lupus nephritis (for example, corticosteroid, cyclophosphamide, mycophenolate mofetil, or azathioprine), B) patient has experienced an intolerance or has a contraindication to standard therapy regimens for lupus nephritis? [If no, then no further questions.]	Yes	No
8	Is the patient new to therapy with the requested drug? [If no, then skip to question 11.]	Yes	No
9	Does the patient have severe active central nervous system lupus? [If yes, then no further questions.]	Yes	No
10	Does the patient have a confirmed diagnosis of lupus nephritis from either of the following: A) kidney biopsy, B) positive for antibodies relevant to systemic lupus erythematosus (SLE) (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins)? [If no, then no further questions.]	Yes	No
11	Is the patient 5 years of age or older?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____