Prescriber Criteria Form

Benlysta 2025 PA Fax 862-A v1 010125.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	Has the patient been diagnosed with active systemic lupus erythematosus (SLE)? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Does the patient meet either of the following criteria: A) patient is currently receiving a stable 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 yes, then skip to question 5.] [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient been diagnosed with active lupus nephritis? [If no, then no further questions.]	Yes ◯	No ◯
4	Does the patient meet either of the following criteria: A) patient is currently receiving a stable 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 ◯
5	Is the patient new to therapy with the requested drug? [If no, then no further questions.]	Yes ◯	No ◯

6	Does the patient have severe active central nervous system lupus?	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:**_____