aetna®

Belimumab (Benlysta®) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Rheumatologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Benlysta: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests

☐ Yes ☐ No Does the patient have a documented diagnosis of active systemic lupus erythematosus based on American College of Rheumatology (ACR) criteria?

☐ Yes ☐ No Has the patient had a positive autoantibody test (anti-nuclear antibody, ANA) or anti-double stranded DNA (anti-dsDNA) test?

☐ Yes ☐ No Has the patient been assessed by any of the following?
→ If yes, please indicate which one was used :
- ☐ SELENA-SLEDAI score
- ☐ British Isles Lupus Assessment Group (BILAG) scores
- ☐ Physician's Global Assessment (PGA) score

☐ Yes ☐ No Has the patient had an insufficient response to any of the following? –
→ If yes, please indicate which one:
- ☐ Glucocorticoids (eg. prednisone, methylprednisolone, dexamethasone
- ☐ Antimalarials (eg. hydroxychloroquine)
- ☐ Immunosuppressives (eg. azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide, chlorambucil, nitrogen mustard)

☐ Yes ☐ No Does the patient's current therapy include any of the following: anti-malarials, corticosteroids, immunosuppressives (excluding IV cyclophosphamide) or non-steroidal anti-inflammatory drugs?

☐ Yes ☐ No Will the patient use belimumab (Benlysta) with other biologics or IV cyclophosphamide?

☐ Yes ☐ No Does the patient have active severe central nervous system (CNS) lupus (including seizures, psychosis, organic brain syndrome, cerebrovascular accident, cerebritis or CNS vasculitis)?

☐ Yes ☐ No Does the patient have active severe lupus nephritis (proteinuria greater than 6 g/24 hour or serum creatinine greater than 2.5mg/dL) or severe active nephritis?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Does the patient require hemodialysis?
☐ Yes ☐ No Does the patient require high-dose prednisone greater than 100mg/day?

For Continuation of Therapy
☐ Yes ☐ No Is there documentation of continued improvement in disease activity indicating a therapeutic response/stability of the disease?
☐ Yes ☐ No Does the patient have evidence of severe renal disease?
☐ Yes ☐ No Does the patient have evidence of active central nervous system lupus?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.