

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

**Please answer the following questions and sign.**

<p>Q1. Is the request for Benlysta injection for subcutaneous use?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is the patient greater than or equal to 18 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the request for Benlysta intravenous infusion?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is the patient 5 years or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Is Benlysta prescribed by or in consultation with an appropriate specialist, such as a rheumatologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the patient have a diagnosis of systemic lupus erythematosus (SLE) or active lupus nephritis (LN) with documentation attached confirming diagnosis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Does the patient have a therapeutic failure, contraindication or intolerance to at least 1 standard therapy (for SLE: hydroxychloroquine, mycophenolate, azathioprine; for LN: mycophenolate, IV or oral cyclophosphamide, azathioprine, oral glucocorticoid)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Q8. Is the patient currently being treated for any active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Requested Duration: <input type="checkbox"/> 12 months	
Q10. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

2023 Medicare Prior Authorization Request