Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Benlysta 120 mg intravenous solution [ ] Benlysta 200 mg/mL subcutaneous auto-injector [ ] Benlysta 200 mg/mL subcutaneous syringe [ ] Benlysta 400 mg intravenous solution
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Active Systemic lupus erythematosus (SLE)

[ ] Active Lupus Nephritis

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q4: Does the member have documentation supporting positive clinical response to therapy? (Check only one that apply)

[ ] Yes (please provide documentation(s) supporting the positive response of the therapy)
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Active Systemic lupus erythematosus (SLE)

[ ] Active Lupus Nephritis

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q6: Is the member autoantibody positive (i.e. anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL)? (Check only one that apply)

[ ] Yes (please specify the test conducted, date of test and test results)
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q7: Is the member currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine)])? (Check only one that apply)

[ ] Yes (please specify drug name(s) and mention the start and end date of the therapy(month/day/year))
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q8: Is the requested medication prescribed by or in consultation with a rheumatologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q9: Does the member currently receives standard of care treatment for active lupus nephritis (e.g., corticosteroids [e.g., prednisone] with mycophenolate or cyclophosphamide)? (Check only one that apply)

[ ] Yes (please specify drug name(s) and mention the start and end date of the therapy(month/day/year))
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

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Q10: Is the requested medication prescribed by or in consultation witha nephrologist or rheumatologist? (Check only one that apply)

[ ] Yes (please specify the prescriber's specialty) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	