



# Belimumab (Benlysta®) Injectable Medication Precertification Request

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

**Please indicate:**  Start of treatment  Continuation of therapy **Today's date:** \_\_\_\_\_ **Date needed:** \_\_\_\_\_

**Ship to:**  Doctor's office  Patient  Other: \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dispensing Provider:**  Aetna Specialty Pharmacy® or  Other: \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **TIN:** \_\_\_\_\_ **PIN:** \_\_\_\_\_

**Precertification Requested By:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

### A. PATIENT INFORMATION

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Patient Current Weight:** \_\_\_\_\_ lbs or \_\_\_\_\_ kgs **Patient 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:** \_\_\_\_\_ *(Circle one):* M.D. D.O. N.P P.A

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **St. Lic. #:** \_\_\_\_\_ **NPI #:** \_\_\_\_\_ **DEA #:** \_\_\_\_\_ **UPIN:** \_\_\_\_\_

**Provider Email:** \_\_\_\_\_ **Office Contact Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

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

### D. DIAGNOSIS INFORMATION

**Primary ICD-9:** \_\_\_\_\_

**Secondary ICD-9:** \_\_\_\_\_ **Other ICD-9 Code:** \_\_\_\_\_

### E. CLINICAL INFORMATION

Yes  No **Is the patient 18 years of age or older with active systemic lupus erythematosus?**

Yes  No **Does the patient have a positive ANA (anti-nuclear antibody) titer greater than or equal to 1:80 and/or anti-dsDNA (double stranded DNA) greater than or equal to 30 IU/ml?**

Yes  No **Is the SLE active as documented by a SELENA-SLEDAI score greater than or equal to 4 while on current treatment regimen?**

Yes  No **Is there evidence of severe active lupus nephritis (proteinuria greater than 6 g/24 hour or equivalent using spot urine protein to creatinine ratio, or serum creatinine greater than 2.5mg/dL)?**

Yes  No **Does the patient require hemodialysis?**

Yes  No **Is there evidence of active central nervous system lupus?**

Yes  No **Does the patient require high-dose prednisone (greater than 100mg/day)?**

Yes  No **Is the patient currently being treated with intravenous cyclophosphamide?**

Yes  No **Is the patient currently being treated with rituximab or any other B cell targeted therapy?**

Yes  No **Does the patient's current therapy include any of the following (alone or in combination): anti-malarials, corticosteroids, immunosuppressives and/or non-steroidal anti-inflammatory drugs?**

### F. PRESCRIPTION INFORMATION – To be completed only if Aetna Specialty Pharmacy is Dispensing Provider

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Benlysta® CPB #0818				

**\*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**

**\*If the prescriber is providing the drug, the provider must verify benefits.**

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)*

**Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space:** \_\_\_\_\_