LUPUS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: ___________________

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date): ___________________**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:

☐ Active systemic lupus erythematosus (SLE) disease WITHOUT active Lupus Nephritis

☐ Active lupus nephritis

☐ Other (ICD code plus description):____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient's weight? _______________ (kg)
2. Is the patient currently being treated with the requested agent? ☐ Yes ☐ No
3. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? ☐ Yes ☐ No
   If yes, is the patient at risk if therapy is changed? ☐ Yes ☐ No
   If yes, please specify risk:____
   ____
4. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: ____
   ____
5. Does the patient have severe active central nervous system lupus? ☐ Yes ☐ No
6. Is the requested agent Lupkynis? ☐ Yes ☐ No
   If yes, will the patient be using the requested agent in combination with cyclophosphamide, Benlysta, or Saphnelo? ☐ Yes ☐ No
7. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., rheumatologist, nephrologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes ☐ No
8. Is the patient's age within FDA labeling for the requested indication for the requested agent and route of administration? ☐ Yes ☐ No
   If no, please provide support for using the requested agent for the patient's age for the requested indication and route of administration: ____
   ____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

9. Is the requested agent Benlysta? ☐ Yes ☐ No
   If yes, will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) Abrilada (adalimumab-afzb), Actemra (tocilizumab), Adalimumab, Adbry (tralokinumab-ldrm), Amjevita (adalimumab-atto), Arcalyst (rilonacept), Avsola (infliximab-axxq), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), Cibinqo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), Enbrel (etanercept), Entyvio (vedolizumab), Fasenra (benralizumab), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Idacio (adalimumab-aacf), Ilaris (canakinumab), Ilumya (tildrakizumab-asmn), Inflectra (infliximab-dyyb), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Leqselvi (deuruxolitinib), Litfulo (ritlecitinib), Nemluvio (nemolizumab-ilto), Nucala (mepolizumab), Olumiant (baricitinib), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orencia (abatacept), Otezla (apremilast), Pyzchiva (ustekinumab-ttwe), Remicade (infliximab), Renflexis (infliximab-abda), Riabni (rituximab-arrx), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), Saphnelo (anifrolumab-fnia), Selarsdi (ustekinumab-aekn), Siliq (brodalumab), Simlandi (adalimumab-ryvk), Simponi (golimumab), Simponi ARIA (golimumab), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Spevigo (spesolimab-sbzo) subcutaneous injection, Stelara (ustekinumab), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tofidence (tocilizumab-bavi), Tremfya (guselkumab), Truxima (rituximab-abbs), Tyenne (tocilizumab-aazg), Tysabri (natalizumab), Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), Yuflyma (adalimumab-aaty), Yusimry (adalimumab-aqvh), Zeposia (ozanimod), Zymfentra (infliximab-dyyb)? ☐ Yes ☐ No
      If yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent? ☐ Yes ☐ No
         If no, is there support for the use of combination therapy (e.g., clinical trials, phase III studies, guidelines)? **Please note, a submitted copy is required.** ☐ Yes ☐ No
10. Can the requested quantity (dose) be achieved with a lower quantity of a higher strength? ☐ Yes ☐ No
   If no, please explain: ____________________

For active systemic lupus erythematosus (SLE) disease WITHOUT active lupus nephritis (LN) requests:

11. Has the patient tried and had an inadequate response to hydroxychloroquine? ☐ Yes ☐ No
   If no, does the patient have an intolerance or hypersensitivity to hydroxychloroquine? ☐ Yes ☐ No
      If yes, please explain intolerance/hypersensitivity: ____________________
      If no, does the patient have an FDA labeled contraindication to hydroxychloroquine? ☐ Yes ☐ No
         If yes, please specify FDA labeled contraindication: ____________________
12. Has the patient tried and had an inadequate response to a corticosteroid OR an immunosuppressive (i.e., azathioprine, methotrexate, cyclophosphamide, mycophenolate)? ☐ Yes ☐ No
   If yes, please specify: ____________________
   If no, does the patient have an intolerance or hypersensitivity to therapy with a corticosteroid OR an immunosuppressive (i.e., azathioprine, methotrexate, cyclophosphamide, mycophenolate)? ☐ Yes ☐ No
      If yes, please explain intolerance/hypersensitivity: ____________________
      If no, does the patient have an FDA labeled contraindication to ALL corticosteroids AND immunosuppressives (i.e., azathioprine, methotrexate, cyclophosphamide, mycophenolate)? ☐ Yes ☐ No
         If yes, please specify FDA labeled contraindication: ____________________
13. Is the patient currently treated with standard SLE therapy (i.e., corticosteroids, hydroxychloroquine, azathioprine, methotrexate, cyclophosphamide, mycophenolate)? ☐ Yes ☐ No
   If yes, please specify: ____________________
14. Will the patient continue standard SLE therapy (i.e., corticosteroids, hydroxychloroquine, azathioprine, methotrexate, cyclophosphamide, mycophenolate)? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For active lupus nephritis requests:

15. Does the patient have Class III, IV, or V lupus nephritis confirmed via kidney biopsy? ☐ Yes ☐ No
16. Will the patient be using the requested agent with background immunosuppressive lupus nephritis therapy (e.g., corticosteroids with mycophenolate or for Benlysta corticosteroids with mycophenolate or IV cyclophosphamide)? ☐ Yes ☐ No

For renewal requests:

17. Has the patient had clinical benefit with the requested agent? ☐ Yes ☐ No

For active systemic lupus erythematosus (SLE) disease WITHOUT active lupus nephritis (LN) renewal requests:

18. Is the patient currently using standard SLE therapy (i.e., corticosteroids, hydroxychloroquine, azathioprine, methotrexate, cyclophosphamide, mycophenolate)? ☐ Yes ☐ No
19. Will the patient continue standard SLE therapy (i.e., corticosteroids, hydroxychloroquine, azathioprine, methotrexate, cyclophosphamide, mycophenolate)? ☐ Yes ☐ No

For active lupus nephritis renewal requests:

20. Is the patient currently using background lupus nephritis therapy (e.g., corticosteroids with mycophenolate or for Benlysta corticosteroids with mycophenolate or IV cyclophosphamide)? ☐ Yes ☐ No
21. Will the patient continue background lupus nephritis therapy (e.g., corticosteroids with mycophenolate or for Benlysta corticosteroids with mycophenolate or IV cyclophosphamide)? ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**

BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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