

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS:

- Does the patient have a diagnosis of systemic lupus erythematosus? Yes No

- Has laboratory testing documented the presence of autoantibodies [e.g. ANA, Anti-dsDNA, Anti-Sm, Anti-Ro/SSA, Anti-La/SSB]? Yes No
If yes, list autoantibody: _____

- Is the patient currently receiving standard immunosuppressive therapy [e.g., hydroxychloroquine, chloroquine, prednisone, azathioprine, methotrexate]? Yes No
If yes, list therapy: _____

- Does the patient have either of the following: Yes No (check which applies)
 - Severe active lupus nephritis
 - Severe active central nervous system lupus

- Is the patient receiving Benlysta in combination with either of the following: Yes No
 - Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]
 - Intravenous cyclophosphamide

Requests for CONTINUATION OF THERAPY:

- Is there documentation of positive clinical response to Benlysta therapy? Yes No

Provider Signature: _____ **Date:** _____

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