CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Benlysta® (belimumab)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI** Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has a diagnosis of active SLE? ☐ Yes ☐ No
- Prior to initiating therapy, is/was patient autoantibody-positive? ☐ Yes ☐ No
- Patient is currently receiving standard therapy for SLE? ☐ Yes ☐ No
  - If yes, please indicate current therapy:

☐ Corticosteroids ☐ Mycophenolate
☐ Azathioprine ☐ Antimalarials (e.g., hydroxychloroquine)
☐ Leflunomide ☐ Non-steroidal anti-inflammatory drugs
☐ Methotrexate ☐ Other _____

- Patient has severe active lupus nephritis or severe active CNS lupus? ☐ Yes ☐ No
- Will Benlysta be given in combination with other biologics or IV cyclophosphamide? ☐ Yes ☐ No
- Patient currently receiving Benlysta? ☐ Yes ☐ No
  - If yes, is patients benefiting from Benlysta therapy? ☐ Yes ☐ No
  - Please indicate benefit(s):

☐ Reduced disease activity ☐ Reduced steroid dose
☐ Reduced flares ☐ Other _____
☐ Reduced use of pain medications

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Benlysta® (belimumab)	☐ 120mg 5ml vial ☐ 400mg 20ml vial	Dose _____ mg/kg Total dose _____ mg Infuse IV over 1 hour every 2 weeks x3 doses then every 4 weeks thereafter		

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)