

BELIMUMAB (BENLYSTA®) PRIOR REVIEW/CERTIFICATION FAXBACK FORM

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5 DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS		CITY	STATE
		STATE	ZIP

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Dx Code: _____

1. Is the patient 18 years or older?..... Yes No

2. Which diagnosis applies to the patient? **(Check appropriate box)**

- active, autoantibody-positive, systemic lupus erythematosus
- severe active lupus nephritis
- severe active central nervous system lupus

Please note: Serious and sometimes fatal infections have been reported in patients receiving immunosuppressive agents, including Benlysta. Caution should be exercised when considering use in patients with a history of chronic infections. Patients receiving therapy for a chronic infection should not receive Benlysta.

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

**For BCBSNC members, fax form to 1-800-795-9403
For NC State Health Plan members (Member ID starts with YPY),
fax form to 1-866-225-5258**