

HEALTHCHOICE

3545 NW 58th St., Ste 500, Oklahoma City, OK 73112
Phone: 1-405-717-8879 or toll-free 1-800-543-6044
FAX: 1-405-717-8947 or 1-405-717-8935

BENLYSTA[®] REQUEST

This form must be completed and accompany all requests. Incomplete forms will not be reviewed.

Billing Provider: _____ Date: _____
Billing Address: _____
TIN: _____ Contact Person: _____
Contact Phone #: _____ Fax #: _____
Patient: _____ DOB: _____
Primary Member: _____ Member ID #: _____
Physician's Name: _____

Note: A physician's letter of medical necessity or six months previous conservative treatment notes must accompany the initial request. Documentation of clinical response must accompany all other requests.

Benlysta[®] Criteria

Diagnosis: Systemic Lupus Erythematosus (SLE) Other _____

Positive ANA test? Yes No Date of Positive Test: _____

PPD Test: Date: _____ Positive? Yes No

STANDARD THERAPY

Must have failed and/or had incomplete response to one or more of the following disease modifying agents:

Imuran [®]	<input type="checkbox"/> Failed	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Incomplete Response
Methotrexate	<input type="checkbox"/> Failed	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Incomplete Response
Arava [®]	<input type="checkbox"/> Failed	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Incomplete Response
CellCept [®]	<input type="checkbox"/> Failed	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Incomplete Response
Azulfidine [®]	<input type="checkbox"/> Failed	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Incomplete Response
Cytoxan [®]	<input type="checkbox"/> Failed	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Incomplete Response
Other: _____	<input type="checkbox"/> Failed	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Incomplete Response

ICD Code(s): _____

CPT Code(s): _____

HCPCS Code(s): _____

**** All information on this form is required for review. Information provided is private and confidential. ****

NOTE: These benefits are applicable only if the patient is an eligible enrolled member of a HealthChoice plan. All benefits are subject to the deductible, coinsurance and policy provisions. Please verify benefits and eligibility by calling the medical claims administrator at 1-405-416-1800 or toll-free 1-800-782-5218.

Medicare Patients: If HealthChoice is the Medicare supplement insurance, authorization from HealthChoice is not required. Please contact Medicare.