reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

BENLYSTA AUTHORIZATION/RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name First Name	Today's Date
Date of Birth: Sex: Weight:	Prescriber Specialty:
Home Phone Number Work Phone Number	Phone Number Fax Number
Home Address City State Zip	Address City State Zip
Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded Insurance ID: Group Number:	Notes: Allergies:

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD10 Code: _____

1. Is the patients diagnosis Antibody Positive Systemic Lupus Erythematosus? ☐ Yes ☐ No
2. Is the patient receiving standard therapy for SLE which may include:
   - ☐ Corticosteroids
   - ☐ Immunosupressives
   - ☐ Antimalarials
   - ☐ NSAIDs
   - ☐ Biologics

   Current Treatment_____
3. Does patient have an active infection? ☐ Yes ☐ No
4. Has patient received a live vaccine within 30 days? ☐ Yes ☐ No
5. Does patient have active lupus nephritis? ☐ Yes ☐ No
6. Does patient have central nervous system lupus? ☐ Yes ☐ No
5. Has patient received intravenous cyclophosphamide within the past 6 months? ☐ Yes ☐ No

   Date received_____

☐ **Authorization** ☐ **Re Authorization****

Drug Name: _____

Dose: _____ ☐ IV ☐ SQ

Frequency: _____

Patient Self-Injecting? ☐ Yes ☐ No

**Re-Authorization:

- Has patient shown improvement of disease status and/or disease stability? ☐ Yes ☐ No

Please submit adequate documentation.