NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

NC DHB Pharmacy Request for Prior Approval Lupus Medications

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
2. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #: _____ NPI ☐ *or* Atypical ☐
8. Prescriber Name: _____
   Requester Contact Information
   Name: _____ Phone #: _____ Ext. _____

Drug Information

9. Drug Name: _____ 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:

Clinical Information

Initial authorization (answer questions 1-6)

1. Does the beneficiary have a diagnosis of active systemic lupus erythematosus (SLE)? ☐ Yes ☐ No
2. Is the medication being prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No
3. Is the beneficiary auto-antibody positive? ☐ Yes ☐ No
4. Is the beneficiary utilizing the medicine in combination with standard treatment regimens (NSAIDs, corticosteroids, anti-malarials, or immunosuppressive drugs) or standard treatment regimens were not tolerated or beneficial? Yes ☐ ☐ No
5. Does the beneficiary have a diagnosis of severe active lupus nephritis or severe active central nervous system lupus? ☐ Yes ☐ No
6. Is the medication being used concurrently with other biologics and/or IV cyclophosphamide? ☐ Yes ☐ No

Initial authorizations can be approved for up to 12 months

For re-authorization answer question 7

7. Is there documented improvement in functional impairment such as fewer flares that required steroid treatment, lower average daily oral prednisone dose, improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits, or sustained improvement in laboratory measures of lupus activity? ☐ Yes ☐ No

Please attach current progress notes documenting disease status and clinical response to the medicine.
Re-authorizations can be approved for up to 12 months

Signature of Prescriber: _____ Date: _____

Fax this form to: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**