

Special Authorization Request Form, for:

BENLYSTA (*belimumab*)

The purpose of this form is to obtain medical information required to assess your request for a drug on the Special Authorization (SA) list of the Reformulary. Please ensure that all information, including contact information, is complete. Completing this form is not a guarantee of approval.

PART 1: COMPLETE THIS INFORMATION

Information about plan member

First name: _____ Last name: _____

Group number: _____ Certificate number: _____

Date of birth (DD/MM/YY): _____ Gender: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Email: _____ Phone: _____

COORDINATION OF BENEFITS

Coverage through another health benefit plan or provincial plan

Do you or your dependents have drug coverage through another health benefits, insurance company or provincial plan? Yes No

If yes, provide the following: Name of plan member: _____

Policy/Plan number: _____ Certificate number: _____

Patient assistance program

Have you enrolled in a patient assistance program? Yes No

If yes, provide your patient assistance program ID number: _____

Provide the patient assistance program:

Contact name: _____ Phone: _____

PART 2: TO BE COMPLETED BY YOUR DOCTOR (PHYSICIAN)

Physician Information

First name: _____ Last name: _____

License: _____ Phone: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Physician's signature: _____

(confirming the below information to be correct)

Drug being requested through Special Authorization

New request Request for continuation of therapy

DIN: _____ Product name: _____

Strength: _____ Dosage: _____

Site of Administration

- Home Private clinic Hospital
 Doctor's office Cancer centre LTC facility

CLINICAL INFORMATION

Diagnosis

Systemic Lupus Erythematosus

Physician specialty

- Physician with experience in the treatment of Systemic Lupus Erythematosus (SLE)
 Rheumatologist

CLINICAL INFORMATION (cont.)

Criteria for initial coverage for Systemic Lupus Erythematosus (SLE), confirm the following:

- Patient is 18 years of age or older; and
- Patient has a diagnosis of active SLE (SELENA - SLEDAI score \geq 6); and
- Patient has positive autoantibody test results and/or anti-dsDNA; and
- Patient has failed to respond to or has contraindications or intolerances to corticosteroids and antimalarials (e.g. hydroxychloroquine or chloroquine) [Specify contraindications or intolerances on last page]

NOTE: Duration of initial approval is 1 year

Request for continuation of therapy, confirm the following:

- Patient demonstrates continued therapeutic benefit, as evidenced by \geq 4 point reduction in SELENA-SLEDAI score

NOTE: Duration of continued approval is 1 year

SPECIAL NOTES

Exclusion criteria: BENLYSTA (belimumab) should not be used in patients with the following:

- severe active lupus nephritis [proteinuria $>$ 6 g/24 hour or equivalent or serum creatinine $>$ 2.5 mg/dL
- severe active central nervous system lupus
- combination use with cyclophosphamide IV
- combination use with other biologics (e.g. rituximab, adalimumab)

Describe any intolerances to therapy: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information that the physician believes is important to this review? _____

Date: January 2022