

A patient's health insurance plan/payer may require prior authorization or supporting documentation to process and cover a claim for treatment with BENLYSTA (belimumab). A prior authorization allows the health plan to review the reason for the requested therapy and to determine medical appropriateness. A patient-specific Letter of Medical Necessity will help to explain the physician's rationale and clinical decision-making in choosing BENLYSTA. Please note that some health plans have specific forms that must be completed to request prior authorization or to document medical necessity.

The following Letter of Medical Necessity template for BENLYSTA can be customized based on your patient's medical history and demographic information.

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## SAMPLE LETTER OF MEDICAL NECESSITY

[Date]

[Plan/Payer Name]

[Payer street address]

[Payer city, state, ZIP code]

Re: Letter of Medical Necessity [HCPCS Code] [Drug Name, Billing Unit]

Patient: [Patient Full Name]

Group/policy Number: [Patient group & policy number]

Date(s) of service: [Date(s)]

Diagnosis: [Code & Description]

Dear [Insert payer contact name and/or department]:

I am writing on behalf of my patient, [patient name/policy number], to document medical necessity for treatment with BENLYSTA (belimumab). The patient will be treated with BENLYSTA for [diagnosis].

This letter serves to document that [patient name] needs BENLYSTA and that BENLYSTA is medically necessary for [him/her] as administered. On behalf of the patient, I am requesting approval for use and subsequent payment for the treatments.

BENLYSTA is indicated for [patients aged  $\geq 5$  with active systemic lupus erythematosus (SLE) or active lupus nephritis who are receiving standard therapy. BENLYSTA is not recommended in patients with severe active central nervous system lupus].

[Patient name] is a/an [age]-year old [male/female] diagnosed with [diagnosis]. [Patient name] has been in my care since [date]. As a result of [diagnosis], my patient [enter brief description of patient history]. Additionally, [patient name] has tried [previous therapies] and [outcomes]. The attached medical records document [patient name]'s clinical condition and medical necessity for treatments with BENLYSTA.

Based on the above facts, I am confident that you will agree that BENLYSTA is indicated and medically necessary for this patient. The plan of treatment is to start the patient on BENLYSTA. Administration of BENLYSTA [dosage] is planned on [date] and will be continued approximately every [frequency]. Please consider coverage of BENLYSTA on [patient name]'s behalf and approve use and subsequent payment for BENLYSTA as planned.

Please refer to the enclosed Prescribing Information for BENLYSTA. If you have any further questions regarding this matter, please do not hesitate to call me at [physician telephone number].

Thank you for your prompt attention to this matter.

Sincerely,

[Physician's name], [degree initials] [physician's practice name]

### Suggested Enclosures:

- Medical records and clinical notes and labs
- FDA approval letter available at:  
<https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=B>
- Prescribing Information (PI) - please also visit:  
[https://gskpro.com/content/dam/global/hcpportal/en\\_US/Prescribing\\_Information/BENLYSTA/pdf/BENLYSTA-PI-MG-IFU.PDF](https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/BENLYSTA/pdf/BENLYSTA-PI-MG-IFU.PDF)
- Important Safety Information

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