HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM **LUPKYNIS™**

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.							
If y	ou have prior authorization question	ons, please call for assistance:	385-425	5-5094			
Disc	claimer: Prior Authorization request fo	orms are subject to change in acco	ordance	with Fede	eral and State notice requirements.		
Date:		Member Name:		ID#:	ID#:		
DOB:		Gender:		Phy	Physician:		
Office Phone:		Office Fax:		Offic	Office Contact:		
Height/Weight:		_I					
Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria. Product being requested: □ Lupkynis™ (voclosporin) Dosing/Frequency:							
If the request is for reauthorization, proceed to reauthorization section.							
	Question	s	Yes	No	Comments/Notes		
	Is the request made by, or in consuor rheumatologist?	ultation with, a nephrologist					
2.	Does documentation show the me positive systemic lupus erythemate	-			Please provide documentation		
	nuclear antibodies [ANA] greater t range and/or anti-double-stranded than 2 times the laboratory referen	han the laboratory reference I DNA [anti-dsDNA] greater					
3.		han the laboratory reference d DNA [anti-dsDNA] greater nce range? ney biopsy showing a			Please provide documentation		
3.	range and/or anti-double-stranded than 2 times the laboratory reference Does documentation include a kide	han the laboratory reference I DNA [anti-dsDNA] greater nce range? ney biopsy showing a hritis Class III, IV, or V?			Please provide documentation Please provide documentation		
3. 4.	range and/or anti-double-stranded than 2 times the laboratory reference Does documentation include a kide histological diagnosis of lupus nepl	han the laboratory reference d DNA [anti-dsDNA] greater nce range? ney biopsy showing a hritis Class III, IV, or V? mL/min/1.73m ² ?			·		
3. 4. 5.	range and/or anti-double-stranded than 2 times the laboratory refered Does documentation include a kide histological diagnosis of lupus nepled the member's recent eGFR ≥ 45. Does the member have a history of Has the member had a trial and fail	han the laboratory reference d DNA [anti-dsDNA] greater nce range? ney biopsy showing a hritis Class III, IV, or V? mL/min/1.73m²? f kidney transplant?			·		
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3. 4. 5. 6. 7.	range and/or anti-double-stranded than 2 times the laboratory reference Does documentation include a kidn histological diagnosis of lupus neptod list he member's recent eGFR ≥ 45. Does the member have a history of Has the member had a trial and fair contraindication/intolerance, to Be Does documentation show Lupkyn with mycophenolate or azathioprince For women of childbearing potentinegative serum pregnancy test at \$1.000.	han the laboratory reference d DNA [anti-dsDNA] greater nce range? ney biopsy showing a hritis Class III, IV, or V? mL/min/1.73m²? f kidney transplant? ilure, or enlysta (belimumab)? is™ will be used concurrently ne AND a systemic steroid? ial, does the member have a screening and negative urine			Please provide documentation Please provide documentation Please provide documentation		

2. Has the member been compliant with background							
immunosuppressive therapy?							
3. Has the member had a positive response to Lupkynis™, such as			Please provide documentation				
improvement or stability in renal function, reduction in flares,							
reduction in corticosteroid dose, decrease of anti-dsDNA titer							
and/or improvement in complement levels?							
What medications and/or treatment modalities have been tried in the past for this condition? Please document							
name of treatment, reason for failure, treatment dates, etc.							
Additional testing and the							
Additional information:							
Physician Signature:							

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Policy: PHARM-CHIP-118 Origination Date: 07/01/2024 Reviewed/Revised Date: Next Review Date:

Current Effective Date: 07/01/2024

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