HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
LUPKYNIS™

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

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.

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, a nephrologist or rheumatologist?	☐	☐	
2. Does documentation show the member has autoantibody-positive systemic lupus erythematosus (SLE), defined as anti-nuclear antibodies [ANA] greater than the laboratory reference range and/or anti-double-stranded DNA [anti-dsDNA] greater than 2 times the laboratory reference range?	☐	☐	**Please provide documentation**
3. Does documentation include a kidney biopsy showing a histological diagnosis of lupus nephritis Class III, IV, or V?	☐	☐	**Please provide documentation**
4. Is the member's recent eGFR ≥ 45 mL/min/1.73m^2?	☐	☐	**Please provide documentation**
5. Does the member have a history of kidney transplant?	☐	☐	
6. Has the member had a trial and failure, or contraindication/intolerance, to Benlysta (belimumab)?	☐	☐	**Please provide documentation**
7. Does documentation show Lupkynis™ will be used concurrently with mycophenolate or azathioprine AND a systemic steroid?	☐	☐	**Please provide documentation**
8. For women of childbearing potential, does the member have a negative serum pregnancy test at screening and negative urine pregnancy test at baseline?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Has the member been compliant with background immunosuppressive therapy?	☐	☐	
3. Has the member had a positive response to Lupkynis™, such as improvement or stability in renal function, reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer and/or improvement in complement levels?	☐	☐	**Please provide documentation**

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 information:

Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 118
Origination Date: 03/30/2021
Reviewed/Revised Date: 05/19/2021
Next Review Date: 05/19/2022
Current Effective Date: 06/01/2021