

SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Lupkynis™ (voclosporin)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- Prescribed by or in consultation with a Nephrologist or Rheumatologist
- Member is 18 years of age or older with a diagnosis of active lupus nephritis Class III, IV, or V as confirmed by renal biopsy
- Member's diagnosis of active, autoantibody-positive SLE was confirmed by **ONE** of the following (**submit lab results for documentation**):
 - anti-nuclear antibody (ANA) titer \geq 1:80
 - anti-double stranded DNA (anti-dsDNA) \geq 30 IU/mL

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- Member has active renal disease and has received standard therapy for the last 90 days with corticosteroids along with **ONE** of the following (**chart notes documenting established therapy must be submitted**):
 - mycophenolate
 - cyclophosphamide
- Provider must obtain a baseline measurement of **ONE** of the following collected within the last 30 days (**submit lab results**):
 - urine protein:creatinine ratio (uPCR)
 - urine protein and urine creatinine
- Member must have tried and failed **TWO** of the following (failure is defined as protein:creatinine ratio not decreasing while on therapy) (**verified by chart notes and/or pharmacy and medical paid claims**):
 - cyclosporine taken daily for the last 90 days
 - rituximab **OR** Gazvya[®] within the last 12 months ***both require PA***
 - Benlysta[®] ***requires PA***

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- All initial authorization criteria continues to be met
- Member has had improvement from baseline and/or stabilization since last approval of **ONE** of the following (**submit current labs completed within the last 30 days**):
 - urine protein:creatinine ratio (uPCR)
 - urine protein and urine creatinine
- Member has an absence of intolerable side effects such as serious infections

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****
****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****