AvMed

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 1-305-671-0200**. 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 can be delayed.**

Drug Requested: Lupkynis™ (voclosporin)

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

Member Name: _____

Member AvMed #: _____ **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 ≥ 1:80
  - ❑ anti-double stranded DNA (anti-dsDNA) ≥ 30 IU/mL

(Continued on next page)

- ❑ 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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~1/21/2021;~~ 1/22/2026
REVISED/UPDATED/REFORMATTED: ~~5/3/2021; 10/11/2021; 2/9/2022.~~ **2/18/2026**