SENTARA COMMUNITY PLAN
(MEDICAID)

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 can 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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

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 Approval: 6 (SIX) months

1. Is the prescriber a rheumatologist, nephrologist, or consulting with a rheumatologist or nephrologist? **AND** ❑ Yes ❑ No
2. Is the member 18 years of age or older? **AND** ❑ Yes ❑ No
3. Does the member have a diagnosis of lupus nephritis? **AND** ❑ Yes ❑ No
4. Is there an International Society of Nephrology/Renal Pathology Society (ISN/RPS) biopsy-proven active Class III or IV lupus nephritis alone or in combination with Class V lupus nephritis? **AND** ❑ Yes ❑ No

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5. Is the urine protein to creatinine ratio (UPCR) ≥ 1.5 mg/mg for Class III or IV or UPCR ≥ 2 mg/mg for Class V? **AND** ❑ Yes ❑ No
6. Is there confirmation that the member does **NOT** have concomitant use of strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin)? **AND** ❑ Yes ❑ No
7. Is there confirmation that the member does **NOT** have severe hepatic impairment? **AND** ❑ Yes ❑ No
8. Is the member concomitantly receiving mycophenolate mofetil and corticosteroids? **AND** ❑ Yes ❑ No
9. Does the member have a baseline blood pressure < 165/105 mm Hg? **AND** ❑ Yes ❑ No
10. Does the member have a baseline estimated glomerular filtration rate (eGFR) > 45 mL/min/1.73 m^2? **AND** ❑ Yes ❑ No
11. Will the member's renal function (eGFR) be assessed at regular intervals thereafter? ❑ Yes ❑ No

Renewal Approval: 6 (SIX) 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.

1. Does the member continue to meet the above criteria? **AND** ❑ Yes ❑ No
2. Has the member experienced disease improvement and/or stabilization or improvement in the slope ofdecline? **AND** ❑ Yes ❑ No
3. Is there confirmation that the member has **NOT** experienced any treatment-restricting adverse effects (e.g., neurotoxicities, irreversible hyperkalemia)? ❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy - PropriumRx

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.