carolina complete health

Pharmacy Prior Approval Request for Lupus Medications- LUPKYNIS

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Initial authorization (answer questions 1-12)

1. Does the beneficiary have a diagnosis of active systemic lupus nephritis? ☐ **Yes** ☐ **No**
2. Does the beneficiary have 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? ☐ **Yes** ☐ **No**
3. What is the beneficiary's urine protein to creatinine (UPCR) ratio?_____
4. Is the beneficiary age 18 or older? ☐ **Yes** ☐ **No**
5. Does the beneficiary have hypersensitivity to any component of the medication? ☐ **Yes** ☐ **No**
6. Is the medication being administered with strong CYP3A4 inhibitors? (ex. Ketoconazole, itraconazole, clarithromycin) ☐ **Yes** ☐ **No**
7. Does the beneficiary have severe hepatic impairment? ☐ **Yes** ☐ **No**
8. Is the beneficiary concomitantly receiving background immunosuppressive therapy? (with the exception of cyclophosphamide) ☐ **Yes** ☐ **No**
9. Please list the beneficiary's baseline blood pressure._____
10. Please list the beneficiary's baseline glomerular filtration rate (eGFR). _____
11. Will renal function (eGFR) be assessed at regular intervals? ☐ **Yes** ☐ **No**
12. Is the medication being prescribed by or in consultation with a rheumatologist? ☐ **Yes** ☐ **No**

For re-authorization (answer questions 13-15)

13. Does the beneficiary continue to meet above criteria? (questions 1-12) ☐ **Yes** ☐ **No**
14. Does the beneficiary show disease improvement and/or stabilization or improvement in the slope of decline? ☐ **Yes** ☐ **No**
15. Has the beneficiary experienced any treatment-restricting adverse effects? (ex. hypertension, neurotoxicities, hyperkalemia) ☐ **Yes** ☐ **No**

****Please attach current progress notes documenting disease status and clinical response to the medicine.****

Signature of Prescriber: _____ Date:_____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (866) 399-0929 Pharmacy PA Call Center: (833) 585-4309