Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

P.O. Box 5119, Helena, MT 59604
Phone 406.443.6002 . Toll-Free 1.800.395.7961
Fax 406.513.1928 . Toll-Free 1.800.294.1350

Montana Healthcare Programs Prior Authorization Request Form for Use of Lupkynis (voclosporin)

Member Name:	DOB:	Date:
Medicaid ID:	Prescriber Phone:	
Prescriber Name/Specialty:	Prescriber Fax:	
Requested Dose/Directions:		

Please complete below information for applicable situation, <u>Initiation</u> or <u>Continuation</u> of therapy:

☐ **INITIATION OF THERAPY:** Member must meet all of the following criteria:

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Medication is being prescribed by a nephrologist or rheumatologist: ☐ Yes ☐ No
3. Member has a diagnosis of active lupus nephritis: ☐ Yes ☐ No
4. Member must have a blood pressure <165/105 mmHg: Most recent blood pressure reading _____
5. Member must have an estimated glomerular filtration rate (eGFR) $\geq$ 45ml/min/1.73^2: Recent eGFR_____
6. Provider has attached clinical documentation of functional impairment due to poor control, which may include but is not limited to limitation of activities of daily living (ADLs) due to pain, impaired ambulation or missing school and/or work: ☐ Yes ☐ No
7. Member is currently on therapy for systemic lupus erythematosus (SLE) and *<u>all of the following are met</u>*:
   - ☐ Member requires daily use of oral corticosteroids, unless contraindicated, ineffective or not tolerated.
   - ☐ Member is on therapeutic dose of mycophenolate mofetil (MMF).
   - ☐ Member is not currently on IV-administered cyclophosphamide

LIMITATIONS: 6 capsules per day/180 capsules per 30 days

Initial authorization will be granted for six months.

☐ **CONTINUATION OF THERAPY:**

1. Provider must provide documentation showing stabliziation of disease or absence of disease progression, AND absence of unacceptable toxicity from drug
2. Prescriber is a nephrologist or rheumatologist: ☐ Yes ☐ No

Reauthorization will be issued for one year.

Please complete form, including required attachments, and fax to
Drug Prior Authorization Unit at 1-800-294-1350.