

## **Lupkynis (voclosporin) Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

			URGENT		
MEMBER INFORMATION					
LAST NAME:		FIRST NAME:			
PHONE NUMBER:		DATE OF BIRTH:			
STREET ADDRESS:					
CITY:		STATE: ZIP CODE	:		
PATIENT INSURANCE ID NUMBER:					
MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES:  FYOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF					
PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):					
PRESCRIBER INFORMATION					
LAST NAME:		FIRST NAME:			
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:			
NPI NUMBER:		DEA NUMBER:			
PHONE NUMBER:		FAX NUMBER:			
STREET ADDRESS:					
CITY:		STATE: ZIP CODE	:		
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:			
MEDICATION OR MEDICAL I	DISPENSING INFORMATION				
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:		
<b>■ NEW THERAPY</b>	RENEWAL	IF RENEWAL: DATE THERAP	Y INITIATED:		
DURATION OF THERAPY (SPE	CIFIC DATES):				

Continued on next page.



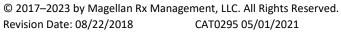


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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:	
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
☐ Lupus Nephritis (LN)		
□ Other diagnosis:	ICD-10:	
<b>3. REQUIRED CLINICAL INFORMATION</b> PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINIC.	AL INFORMATION TO SUPPORT A
Clinical Information:		
Is this drug being prescribed to this patrial?   ☐ Yes ☐ No	tient as part of a treatment regimen sp	ecified within a sponsored clinical
Does the patient have Class III/Class IV	/ disease? □ Yes □ No Please submit docu	ımentation.
Does the patient have Class V disease	P 🗆 Yes 🗆 No Please submit documentation	n.
Does the patient have a urine protein <i>Please submit documentation.</i>	to creatinine (UPCR) ratio of ≥1.5 mg/m	ng? □ Yes □ No
Does the patient have a urine protein <i>Please submit documentation.</i>	to creatinine (UPCR) ratio of ≥2 mg/mg	?□ Yes □ No
Does the patient have an estimated gl Please submit documentation.	omerular filtration rate (eGFR) of ≤45 m	nL/minute?   Yes   No
Will the patient take Lupkynis with my	rcophenolate? □ Yes □ No	
Will the patient take Lupkynis with lov	v-dose steroids? □ Yes □ No	
Has the patient tried and failed, or have Please submit documentation.	ve an absolute contraindication to, Benl	ysta (belimumab)? 🗆 Yes 🗆 No
Is Lupkynis being prescribed by, or in o	consultation with, a nephrologist or rhe	umatologist? 🗆 Yes 🗆 No
Are there any other comments, diagnorphysician feels is important to this rev	oses, symptoms, medications tried or fa iew?	iled, and/or any other information the
<b>Please note:</b> Not all drugs/diagnosis are information is received.	e covered on all plans. This request may	be denied unless all required









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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
<b>ATTESTATION:</b> I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.				
Prescriber Signature or Electronic I.D. Verification:	Date:			
you are not the intended recipient, you are hereby notified that any	mission contain confidential health information that is legally privileged. If disclosure, copying, distribution, or action taken in reliance on the contents formation in error, please notify the sender immediately (via return FAX)			

**FAX THIS FORM TO: 800-424-7640** 

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811

