AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Lupkynis

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___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 ratio (UPCR)? Yes___ No___
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___

Reauthorization: (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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406