WellCare
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NC Medicaid and NC Health Choice
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-provenactive 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**

☐ Is the beneficiary concomitantly receiving background immunosuppressive therapy? (with the exception of cyclophosphamide) ☐ **Yes** ☐ **No**

8. Please list the beneficiary's baseline blood pressure._____
9. Please list the beneficiary's baseline glomerular filtration rate (eGFR). _____
10. Will renal function (eGFR) be assessed at regular intervals? ☐ **Yes** ☐ **No**
11. Is the medication being prescribed by or in consultation with a rheumatologist? ☐

Yes ☐ **NoFor re-authorization (answer questions 13-15)**

12. Does the beneficiary continue to meet above criteria? (questions 1-12) ☐ **Yes** ☐ **No**
13. Does the beneficiary show disease improvement and/or stabilization or improvement in the slope of decline? ☐ **Yes** ☐ **No**
14. 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.****

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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 **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**