pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

LUPKYNIS (voclosporin) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Immunosuppressives, Oral** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: ___________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication: ☐Lupkynis capsule ☐Lupkynis ___________________________	Strength:	Quantity per fill:	Refills:
Directions:			

Diagnosis:	Dx code (*required*):
Is Lupkynis prescribed by or in consultation with a specialist, such as a nephrologist or rheumatologist?	☐Yes ☐No *Submit documentation of consultation with specialist, if applicable.*
Does the beneficiary have kidney or liver impairment that necessitates an adjustment of the dose of Lupkynis?	☐Yes ☐No *Submit documentation.*
Does the beneficiary have a diagnosis of lupus nephritis that is confirmed by kidney biopsy?	☐Yes ☐No *Submit documentation.*
Will the beneficiary be taking Lupkynis in addition to background immunosuppressive therapy? Check all that apply. ☐mycophenolate mofetil/mycophenolic acid ☐prednisone or other corticosteroid ☐other (list): ____ ____	☐Yes ☐No *Submit documentation of complete current medication list.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:

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