maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Lupkynis

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the requested medication be used in combination with other biologics? [Note: Examples of biologics include but not limited to Benlysta (belimumab), adalimumab SC products (for example, Humira (adalimumab), biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV products (for example, Remicade, biosimilars), a rituximab IV products (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC).] [If yes, no further questions.]	Yes	No
2	Will the requested medication be used in combination with cyclophosphamide? [If yes, no further questions.]	Yes	No

If you have any questions, call: 1-888-258-8250

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3	Is the patient currently receiving the requested medication? [If no, skip to question 14.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 14.]	Yes	No
5	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 14.] [If no, no further questions.]	Yes	No
7	Has the patient been established on therapy for at least 3 months? [If no, skip to question 14.]	Yes	No
8	What is the indication or diagnosis? [] Lupus Nephritis (If checked, go to 9) [] Plaque Psoriasis (If checked, no further questions) [] Other (If checked, no further questions)		
9	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? [Note: Examples of a response include improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, and improvement in complement levels (for example, C3, C4).] [If no, no further questions.]	Yes	No
10	Is the requested medication being used concurrently with a systemic corticosteroid and mycophenolate mofetil unless intolerant to or contraindicated? [If no, no further questions.]	Yes	No
11	Does the patient have an estimated glomerular filtration rate (eGFR) GREATER THAN 45 mL/min/m^2? [If no, no further questions.]	Yes	No
12	Does the patient have a blood pressure of LESS THAN OR EQUAL TO 165/105 mmHg? [If no, no further questions.]	Yes	No

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13	Is the requested medication being prescribed by or in consultation with a nephrologist or a rheumatologist? [No further questions.]	Yes	No
14	What is the indication or diagnosis? [] Lupus Nephritis (If checked, go to 15) [] Plaque Psoriasis (If checked, no further questions) [] Other (If checked, no further questions)		
15	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
16	Has documentation been submitted to confirm that the patient has a clinical diagnosis of lupus nephritis that has been confirmed on biopsy? ACTION REQUIRED: Submit supporting documentation. [Note: For example, World Health Organization class III, IV, or V lupus nephritis with a urine protein to creatinine (UPCR) ratio greater than or equal to 1.5 mg/mg.] [If no, no further questions.]	Yes	No
17	Does the patient have autoantibody-positive systemic lupus erythematosus (SLE), defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA antibody (anti-dsDNA)? [If no, no further questions.]	Yes	No
18	Will the requested medication be used concurrently with a systemic corticosteroid and mycophenolate mofetil? [If yes, skip to question 20.]	Yes	No
19	Has documentation been provided to confirm that the patient had an intolerance or contraindication to a systemic corticosteroid and mycophenolate mofetil? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Does the patient have an estimated glomerular filtration rate (eGFR) GREATER THAN 45 mL/min/m^2? [If no, no further questions.]	Yes	No
21	Does the patient have a baseline blood pressure of LESS THAN OR EQUAL TO 165/105 mmHg? [If no, no further questions.]	Yes	No
22	Has documentation been provided to confirm that the patient has had an intolerance to, contraindication to, or trial and failure to at least two of the following agents: corticosteroids, azathioprine, cyclophosphamide, or mycophenolate? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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23	Is this medication being prescribed by or in consultation with a nephrologist or a rheumatologist? [If no, no further questions.]	Yes	No
24	Will the requested medication be used in combination with any strong CYP3A4 inhibitors such as ketoconazole, itraconazole, clarithromycin with the requested medication?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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