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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request for an INITIAL or a CONTINUATION of therapy?

[] Initial (If checked, go to 6)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 6.]

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

Version 04.2026

PRIOR AUTHORIZATION REQUEST

3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 6.]	Yes	No
4	Does the patient have a previously approved prior authorization (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 no, skip to question 6.]	Yes	No
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of a response include improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, decrease of anti-double-stranded deoxyribonucleic acid (anti-dsDNA) titer, and improvement in complement levels (for example, C3, C4).] [No further questions.]	Yes	No
6	What is the indication or diagnosis? [] Lupus Nephritis (If checked, go to 7) [] Other (If checked, no further questions)		
7	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
8	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
9	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
10	Will the requested medication be used in combination with cyclophosphamide? [If yes, no further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

11	Will the requested medication be used in combination with any strong CYP3A4 inhibitors such as ketoconazole, itraconazole, clarithromycin? [If yes, no further questions.]	Yes	No
12	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
13	Does the patient have an estimated glomerular filtration rate (eGFR) GREATER THAN 45 mL/min/m^2? [If no, no further questions.]	Yes	No
14	Does the patient have a baseline blood pressure of LESS THAN OR EQUAL TO 165/105 mmHg? [If no, no further questions.]	Yes	No
15	Has documentation been submitted to confirm that the patient has had a treatment failure with AT LEAST 2 of the following agents: corticosteroids, azathioprine, cyclophosphamide, or mycophenolate unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Is this medication being prescribed by or in consultation with a nephrologist or a rheumatologist? [If no, no further questions.]	Yes	No
17	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 23.7 mg twice daily in combination with corticosteroids and mycophenolate.]	Yes	No

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

SECTION B: Physician Signature

PRIOR AUTHORIZATION REQUEST

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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

Version 04.2026