



STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

VOCLOSPORIN

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
VOCLOSPORIN	LUPKYNIS	47077		GPI-10 (9940208000)	

GUIDELINES FOR USE

INITIAL CRITERIA

- Does the patient have a diagnosis of active lupus nephritis (LN) and meet **ALL** of the following criteria?
 - The patient is 18 years of age or older
 - Therapy is prescribed by or given in consultation with a rheumatologist or nephrologist
 - The requested medication will be used in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil, corticosteroids)

If yes, **approve for 6 months by HICL or GPI-10 with a quantity limit of #6 per day.**

APPROVAL TEXT: Renewal requires improvement in renal response from baseline laboratory values (eGFR or proteinuria) and/or clinical parameters (e.g., fluid retention, use of rescue drugs, glucocorticoid use).

If no, do not approve.

INITIAL DENIAL TEXT: ***Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.**

Our guideline named **VOCLOSPORIN (Lupkynis)** requires the following rule(s) be met for approval:

- A. You have active lupus nephritis (LN: inflammation of the kidneys caused by lupus when the immune system attacks its own tissues)
- B. You are 18 years of age or older
- C. Therapy is prescribed by or given in consultation with a rheumatologist (doctor who specializes in conditions that affect the muscles and skeletal system, especially the joints) or nephrologist (doctor who specializes in the kidney)
- D. The requested medication will be used in combination with a background immunosuppressive therapy regimen (such as mycophenolate mofetil, corticosteroids)

Your doctor told us **[INSERT PT SPECIFIC INFO PROVIDED]**. We do not have information showing you **[INSERT UNMET CRITERIA]**. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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VOCLOSPORIN

GUIDELINES FOR USE (CONTINUED)

RENEWAL CRITERIA

1. Does the patient have a diagnosis of active lupus nephritis (LN) **AND** meet the following criterion?
 - The patient has improvement in renal response from baseline laboratory values (i.e., eGFR or proteinuria) and/or clinical parameters (e.g., fluid retention, use of rescue drugs, glucocorticoid use)

If yes, **approve for 12 months by HICL or GPI-10 with a quantity limit of #6 per day.**
If no, do not approve.

RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **VOCLOSPORIN (Lupkynis)** requires the following rule(s) be met for renewal:

- A. You have active lupus nephritis (LN: inflammation of the kidneys caused by lupus when the immune system attacks its own tissues)
- B. You have improvement in renal response from baseline laboratory values (eGFR [measurement of kidney function] or proteinuria [level of protein in urine]) and/or clinical parameters (such as fluid retention, use of rescue drugs, glucocorticoid use)

Your doctor told us **[INSERT PT SPECIFIC INFO PROVIDED]**. We do not have information showing you **[INSERT UNMET CRITERIA]**. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Lupkynis.

REFERENCES

- Lupkynis [Prescribing Information]. Victoria, BC: Aurinia Pharmaceuticals Inc.; January 2021.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A

Commercial Effective: 02/05/21

Created: 02/21

Client Approval: 02/21

P&T Approval: 10/20