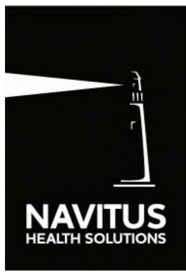


TEXAS MEDICAID
Clinical Edit Prior Authorization
voclosporin (LUPKYNIS)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: ________________________________ ICD 10 Code: __________

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of lupus nephritis (LN) in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Is the client receiving standard immunosuppressive therapy?

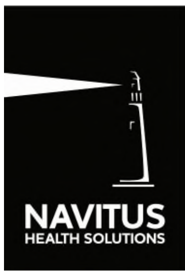
   Examples of standard immunosuppressive therapy include azathioprine (IMURAN), chloroquine, hydroxychloroquine (PLAQUENIL), methotrexate (OTREXUP, TREXALL, XATMEP), mycophenolate mofetil (CELLCELPT), mycophenolate acid (MYFORTIC), and prednisone.

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Has the client had a claim for a strong CYP3A4 inhibitor in the last 90 days?

   Examples of strong CYP3A4 inhibitors include clarithromycin (BIAXIN), itraconazole (SPORANOX, TOLSURA), ketoconazole, KORLYM, lansoprazole-amoxicillin-clarithromycin (PREVPAC), nefazodone, OMECLAMOX-PAK, NOXAFIL, VIEKIRA, voriconazole (VFEND), ZYDELIG, and certain HIV treatments (e.g. ATAZANAVIR, CRIXIVAN, EVOTAZ, GENVOYA, INVIRASE, KALETRA, ritonavir (NORVIR), PREZCOBIX, PREZISTA, REYATAZ, STRIBILD, SYMTUZA, TYBOST, and VIRACEPT).

   ☐ Yes (Deny) ☐ No (Go to #5)



5. Is the client currently taking cyclophosphamide?

☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a diagnosis of hypertensive emergency in the last 60 days?

☐ Yes (Deny) ☐ No (Go to #7)

7. Does the client have a diagnosis of end stage renal disease (ESRD) in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #8)

8. Does the client have a diagnosis of severe renal impairment or mild to moderate hepatic impairment in the last 365 days?

☐ Yes (Go to #9) ☐ No (Go to #10)

9. Is the dose less than or equal to (≤) 15.8mg twice daily?

☐ Yes (Approve – 180 days) ☐ No (Deny)

10. Is the dose less than or equal to (≤) 23.7mg twice daily?

☐ Yes (Approve – 180 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: ____ **Date:** ____________

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.