Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Lupus: Lupkynis

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy (**in Days**): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Initial authorization (answer questions 1-12)

1. Does the member have a diagnosis of active systemic lupus nephritis? ☐ **Yes** ☐ **No**
2. Does the member have International Society of Nephrology/Renal Pathology Society (ISN/RPS) biopsy-proven active Class III or IV Lupus Nephritis alone or in combination with Class V Lupus Nephritis? ☐ **Yes** ☐ **No**
3. What is the member's urine protein to creatinine (UPCR) ratio?
4. Is the member age 18 or older? ☐ **Yes** ☐ **No**
5. Does the member have hypersensitivity to any component of the medication? ☐ **Yes** ☐ **No**
6. Is the medication being administered with strong CYP3A4 inhibitors? (ex. Ketoconazole, itraconazole, clarithromycin) ☐ **Yes** ☐ **No**
7. Does the member have severe hepatic impairment? ☐ **Yes** ☐ **No**
8. Is the member concomitantly receiving background immunosuppressive therapy? (with the exception of cyclophosphamide) ☐ **Yes** ☐ **No**
9. Please list the member's baseline blood pressure _____
10. Please list the member's baseline glomerular filtration rate (eGFR) _____
11. Will renal function (eGFR) be assessed at regular intervals? ☐ **Yes** ☐ **No**
12. Is the medication being prescribed by or in consultation with a rheumatologist? ☐ **Yes** ☐ **No**

For re-authorization (answer questions 13-15)

13. Does the member continue to meet above criteria? (questions 1-12) ☐ **Yes** ☐ **No**
14. Does the member show disease improvement and/or stabilization or improvement in the slope of decline? ☐ **Yes** ☐ **No**
15. Has the member experienced any treatment-restricting adverse effects? (ex. hypertension, neurotoxicities, hyperkalemia) ☐ **Yes** ☐ **No**

****Please attach current progress notes documenting disease status and clinical response to the medicine. ****

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277