

**LUPKYNIS (voclosporin) PRIOR AUTHORIZATION FORM** *(form effective 01/03/2022)*

Prior authorization guidelines for **Immunosuppressives, Oral** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at <https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	
Beneficiary address:		Beneficiary phone number:		

**CLINICAL INFORMATION**

Medication:	<input type="checkbox"/> Lupkynis capsule <input type="checkbox"/> Lupkynis _____	Strength:	Quantity per fill:	Refills:
Directions:				
Diagnosis:			Dx code ( <i>required</i> ):	
Is Lupkynis prescribed by or in consultation with a specialist, such as a nephrologist or rheumatologist?			<input type="checkbox"/> Yes <i>Submit documentation of consultation with specialist, if applicable.</i> <input type="checkbox"/> No	
Does the beneficiary have kidney or liver impairment that necessitates an adjustment of the dose of Lupkynis?			<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
Does the beneficiary have a diagnosis of lupus nephritis that is confirmed by kidney biopsy?			<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
Will the beneficiary be taking Lupkynis in addition to background immunosuppressive therapy? Check all that apply.				
<input type="checkbox"/> mycophenolate mofetil/mycophenolic acid <input type="checkbox"/> prednisone or other corticosteroid <input type="checkbox"/> other (list): _____ _____			<input type="checkbox"/> Yes <i>Submit documentation of complete current medication list.</i> <input type="checkbox"/> No	

GHP Family Pharmacy Customer Service  
100 N. Academy Ave.  
Danville, PA 17822  
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com



**Please submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.**

**Prescriber Signature:**

**Date:**

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