

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1359-1
Program	Prior Authorization/Notification
Medications	Lupkynis™ (voclosporin)
P&T Approval Date	6/2021
Effective Date	6/15/2021; Oxford only: N/A

1. Background:

Lupkynis is a calcineurin-inhibitor immunosuppressant indicated in combination with a background immunosuppressive therapy regimen for the treatment of adult patients with active lupus nephritis (LN).

Limitation of use:

Safety and efficacy of Lupkynis have not been established in combination with cyclophosphamide. Use of Lupkynis is not recommended in this situation.

2. Coverage Criteria:

A. Initial Authorization

1. Lupkynis will be approved based on **ALL** of the following criteria:

a. Diagnosis of active lupus nephritis

-AND-

b. Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)

-AND-

c. Patient is not receiving Lupkynis in combination with cyclophosphamide

Authorization will be issued for 6 months.

B. Reauthorization

1. Lupkynis will be approved based on the following criteria:

a. Documentation of positive clinical response to Lupkynis therapy

-AND-

b. Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)

-AND-

c. Patient is not receiving Lupkynis in combination with cyclophosphamide

Authorization will be issued for 6 months.

3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program.
- Supply limitations may be in place.

4. References:

1. Lupkynis [package insert]. Rockville, MD: Aurinia Pharma U.S., Inc.; January 2021.

Program	Prior Authorization/Notification - Lupkynis (voclosporin)
Change Control	
6/2021	New program.