Voclosporin (Lupkynis)

Coverage Criteria:

1. Prescribed by a rheumatologist or nephrologist; and,
2. The patient has a documented diagnosis of Class III, IV, and/or V lupus nephritis. Medical documentation confirming the diagnosis must be provided; and,
3. Patient has a baseline eGFR > 45mL/min/1.73m(2); and,
4. A previous treatment course of mycophenolate mofetil for at least six months resulting in failure or adverse events; and,
5. A previous treatment course of cyclophosphamide for at least six months resulting in failure or adverse events, and,
6. Trial and failure of (or medical contraindications to) at least one generic calcineurin inhibitor (cyclosporine or tacrolimus); and,
7. The medication will not be prescribed in combination with Benlysta; and,
8. Prescribed within the FDA-approved dosing regimen.

Coverage Duration:

Initial authorizations will be for 6 months.
Re-authorizations will be for 12 months.

Renewal Criteria:

1. Patient continues to meet initial prior authorization criteria (1), (3), (7), and (8); and,
2. Patient has been seen by the specialist within the past 14 months; and,
3. Patient meets one of the following:
    a. Treated with Lupkynis for less than 52 weeks with provider attestation that the medication has been effective; or,
    b. The patient has been treated with Lupkynis for at least 52 weeks with a complete renal response. A complete renal response is defined as:
        i. Urine protein-creatinine ratio (UPCR) of ≤0.5 mg/mg; and
        ii. eGFR ≥ 60 mL/min/1.73m(2); or
        iii. No confirmed decrease from baseline in eGFR of >20%; and
        iv. Patient has not received rescue medication for lupus nephritis.