CVS caremark™ {{PANUMCODE}}

Lupkynis

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
   ❑ Active lupus nephritis ❑ Other _____
2. What is the ICD-10 code? _____
3. Will the patient be using the requested medication in combination with cyclophosphamide? ❑ Yes ❑ No
4. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #6*
5. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition? ***ACTION REQUIRED: If Yes, attach medical records (e.g., chart notes, lab reports) documenting stability or improvement.*** ❑ Yes ❑ No *No further questions.*
6. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins) or was lupus nephritis confirmed on kidney biopsy? ***ACTION REQUIRED: If Yes, attach medical records (e.g., chart notes, lab reports) documenting the presence of autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins), or kidney biopsy supporting the diagnosis.***
   ❑ Yes ❑ No ❑ Unknown
7. Does the patient have clinically active lupus renal disease? ❑ Yes ❑ No
8. Is the patient currently receiving background therapy with mycophenolate mofetil (MMF) with corticosteroids?
   ❑ Yes ❑ No
9. What is the patient's eGFR per ml/min/1.73m^2? _____ ml/min/1.73m^2

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155