coordinated care

Neuromuscular Agents – Lupus Agents

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this a request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response from baseline measurements? ☐ Yes ☐ No

2. Indicate the patient's diagnosis:
   ☐ Lupus nephritis (active class III or IV, with or without class V) confirmed by renal biopsy
   ☐ Systemic Lupus Erythematosus (SLE) with laboratory results showing active disease and autoantibody-positive tests (e.g., anti-nuclear antibody [ANA] or anti-double stranded DNA [anti-dsDNA]
   ☐ Other. Specify: _____

3. Was this prescribed by, or in consultation with a rheumatologist or nephrologist? ☐ Yes ☐ No

4. Indicate patients baseline and/or current assessments for one of the following measurements:

   Urinary protein to creatinine ratio
   Baseline: _____ Date taken: _____
   If a continuation, current: _____ Date taken: _____

   Estimated Glomerular Filtration Rate (eGFR)
   Baseline eGFR: _____ mL/min/m^2 Date taken:_____
   If a continuation, current eGFR: _____ mL/min/m^2 Date taken:_____

   If none of the above, for Systemic Lupus Erythematosus (SLE), has a baseline assessment been conducted using one of the following functional assessment tools? (check all that apply)
   ☐ SLE Index Score (SIS)
   ☐ British Isles Lupus Assessment Group (BILAG)
   ☐ Systemic Lupus Activity Measure (SLAM)
   ☐ Systemic Lupus Erythematosus Disease Activity Score (SLEDAI)
   ☐ Physicians Global Assessment (PGA)
   ☐ Systemic Lupus International Collaborating Clinic (SLICC) Damage Index

5. Will patient continue any of the following therapies (check all that apply):
   - ☐ Belimumab (if request is for voclosporin)
   - ☐ Corticosteroid (i.e., prednisone, methylprednisolone). Specify: _____
   - ☐ Immunosuppressant (i.e., mycophenolate, cyclophosphamide, azathioprine). Specify_____
     If request for Voclosporin (Lupkynis), confirm patient will not use in combination with tacrolimus cyclophosphamide? ☐ Yes ☐ No
   - ☐ Hydroxychloroquine
   - ☐ NSAIDs

For Voclosporin (Lupkynis):

6. Does the patient have a history of treatment with belimumab used for Lupus Nephritis that has been ineffective, not tolerated, or contraindicated?
   - ☐ No
   - ☐ Yes. Explain:_____

REQUIRED WITH THIS REQUEST

- **Chart notes**
- **Laboratory results showing active disease**
- **Functional assessments - baseline and current if applicable**

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)