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

Geisinger

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

☐New request ☐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:

CLINICAL INFORMATION

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

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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