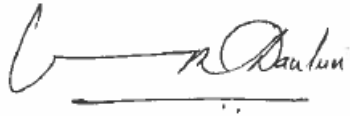


## Prior Authorization Review Panel

### CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.  
Policies submitted without this form will not be considered for review.

<b>Plan: PA Health &amp; Wellness</b>	<b>Submission Date: 11/2021</b>
<b>Policy Number: PHW.PDL.229</b>	<b>Effective Date: 01/01/2020</b> <b>Revision Date: 10/2021</b>
<b>Policy Name: Immunosuppressives, Oral</b>	
<p><b>Type of Submission – <u>Check all that apply</u>:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> New Policy</li> <li><input checked="" type="checkbox"/> Revised Policy*</li> <li><input type="checkbox"/> Annual Review - No Revisions</li> <li><input checked="" type="checkbox"/> <b>Statewide PDL</b> - <i>Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.</i></li> </ul>	
<p><b>*All revisions to the policy <u>must</u> be highlighted using track changes throughout the document.</b></p> <p><b>Please provide any changes or clarifying information for the policy below:</b></p> <p style="margin-top: 20px;">Q1 2022: revised according to DHS revisions effective 01/03/2022.</p>	
<b>Name of Authorized Individual (Please type or print):</b>  <b>Venkateswara R. Davuluri, MD</b>	<b>Signature of Authorized Individual:</b>  

## Clinical Policy: Immunosuppressives, Oral

Reference Number: PHW.PDL.229

Effective Date: 01/01/2020

Last Review Date: 10/2021

[Revision Log](#)

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with PA Health and Wellness® that Oral Immunosuppressive Agents are **medically necessary** when the following criteria are met:

### I. Requirements for Prior Authorization of Immunosuppressives, Oral

#### A. Prescriptions That Require Prior Authorization

Prescriptions for Immunosuppressives, Oral that meet any of the following conditions must be prior authorized:

1. A non-preferred Immunosuppressive, Oral. See the Preferred Drug List (PDL) for the list of preferred Immunosuppressives, Oral at: <https://papdl.com/preferred-drug-list>.
2. An Immunosuppressive, Oral with a prescribed quantity that exceeds the quantity limit..

#### B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Immunosuppressive, Oral, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. Is prescribed the Immunosuppressive, Oral for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**
2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. Does not have a contraindication to the requested medication; **AND**
4. For Lupkynis (voclosporin), **all** of the following:
  - a. For the treatment of lupus nephritis, has a diagnosis of active lupus nephritis that is confirmed by a kidney biopsy unless a kidney biopsy is not medically advisable,
  - b. Is prescribed Lupkynis (voclosporin) by or in consultation with an appropriate

- specialist (e.g., nephrologist, rheumatologist),
- c. Is prescribed Lupkynis (voclosporin) in combination with background immunosuppressive therapy as tolerated,
- d. Is not prescribed Lupkynis (voclosporin) in combination with cyclophosphamide or Benlysta (belimumab);

**AND**

- 5. For all other non-preferred Immunosuppressives, Oral, **one** of the following:
  - a. Has a documented history of therapeutic failure of or a contraindication or an intolerance to the preferred Immunosuppressives, Oral approved or medically accepted for the member's diagnosis
  - b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Immunosuppressive, Oral;

**AND**

- 6. If a prescription for an Immunosuppressive, Oral is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

**C. Clinical Review Process**

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Immunosuppressive, Oral. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member.

**D. Approval Duration: 12 months**

**E. References:**

- 1. Lupkynis [package insert]. Rockville, MD: Aurinia Pharma U.S., Inc. January 2021.
- 2. Falk RJ, Dall'Era M, Appel GB. Lupus nephritis: Initial and subsequent therapy for focal or diffuse lupus nephritis. In: UpToDate [internet database]. Glasscock RJ,

- Rovin BH, Lam AQ, Ramirez Curtis M, eds. Waltham, MA: UpToDate Inc. Updated September 15, 2021. Accessed October 11, 2021.
3. Falk RJ, Dall'Era M, Appel GB. Lupus nephritis: Treatment of focal or diffuse lupus nephritis resistant to initial therapy. In: UpToDate [internet database]. Glasscock RJ, Rovin BH, Lam AQ, Ramirez Curtis M, eds. Waltham, MA: UpToDate Inc. Updated October 14, 2021. Accessed October 26, 2021.
  4. Fanouriakis A, Kostopoulou M, Cheema K, et al. 2019 update of the Joint European League Against Rheumatism and European Renal Association – European Dialysis and Transplant Association (EULAR/ERA-EDTA) recommendations for the management of lupus nephritis. *Ann Rheum Dis*. 2020;79:713-723.
  5. Tice JA, Mandrik O, Thokala P, et al. Voclosporin and belimumab for lupus nephritis: Effectiveness and value; evidence report. Institute for Clinical and Economic review, April 16, 2021. [https://icer.org/wp-content/uploads/2020/11/ICER\\_Lupus-Nephritis\\_Final-Evidence-Report\\_041621.pdf](https://icer.org/wp-content/uploads/2020/11/ICER_Lupus-Nephritis_Final-Evidence-Report_041621.pdf)
  6. Rovin BH, Adler SG, Barratt J, et al. KDIGO 2021 clinical practice guideline for the management of glomerular diseases. *Kidney International*. 2021;100(4S):S1-S276.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022: revised according to DHS revisions effective 01/03/2022.	10/2021