Neuromuscular Agents – Lupus Agents

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision. Allow at least 24 hours for review.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

United Healthcare Community Plan

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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:_____

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REQUIRED WITH THIS REQUEST • **Chart notes** • **Laboratory results showing active disease** • **Functional assessments - baseline and current if applicable**

Prescriber signature	Prescriber specialty	Date