**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# Immunosuppressives - Oral

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| | | |
|---|---|---|
| Member Name: | Prescriber Name: | |
| HPP Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Member Primary Phone: | NPI: | *PA PROMISe ID:* |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | *Specialty Pharmacy (if applicable):* | |
| **Drug Name:** | **Strength:** | |
| **Quantity:** | **Refills:** | |
| **Directions:** | | |
| **Diagnosis Code:** | **Diagnosis:** | |

*HPP's maximum approval time is 12 months but may be less depending on the drug.*

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
***Please answer the following questions and sign.***

Q1. The member 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.

☐ Yes ☐ No

Q2. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q3. The member does not have a contraindication to the requested drug.

☐ Yes ☐ No

Q4. 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.

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| Member Name: | Prescriber Name: |
|---|---|

☐ d. Is not prescribed Lupkynis (voclosporin) in combination with cyclophosphamide or Benlysta (belimumab).

Q5. For all other non-preferred Immunosuppressives, Oral, one of the following:

☐ 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 beneficiary's diagnosis

☐ Has a current history (within the past 90 days) of being prescribed the same non-preferred Immunosuppressive, Oral (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred).

Q6. Additional Information:

Prescriber Signature

Date

*v2026*