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Last P&T Approval/Version: 10/29/2025  
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Policy Number: C21124-A

## Lupkynis (voclosporin)

### PRODUCTS AFFECTED

Lupkynis (voclosporin)

### COVERAGE POLICY

*Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.*

#### **Documentation Requirements:**

*Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.*

#### **DIAGNOSIS:**

Lupus Nephritis

#### **REQUIRED MEDICAL INFORMATION:**

This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

#### **A. LUPUS NEPHRITIS:**

1. Documented diagnosis of systemic lupus erythematosus (SLE)  
AND

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## Drug and Biologic Coverage Criteria

2. Documentation of kidney biopsy with a histologic diagnosis of lupus nephritis Classes III, IV, V to confirm diagnosis of active lupus nephritis [DOCUMENTATION REQUIRED]  
AND
3. Documentation the member does not have baseline eGFR  $\leq$  45 mL/min/1.73 m<sup>2</sup> OR the prescriber attests that the benefit exceeds the increased risk of acute and/or chronic nephrotoxicity  
AND
4. Member has a baseline blood pressure  $\leq$  165/105 mmHg  
AND
5. Prescriber attests to (or the clinical reviewer has found that) the member not having any FDA labeled contraindications that haven't been addressed by the prescriber within the documentation submitted for review [Contraindications to Lupkynis (voclosporin) include: Patients concomitantly using strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin), known serious or severe hypersensitivity reaction to Lupkynis or any of its excipients, avoid use in patients with severe hepatic impairment]  
AND
6. Lupkynis (voclosporin) will NOT be used concurrently with cyclophosphamide or Benlysta  
NOTE: Safety and efficacy of Lupkynis have not been established in combination with cyclophosphamide. Use of Lupkynis is not recommended in this situation.  
AND
7. Lupkynis (voclosporin) will be used concurrently with standard therapy (i.e., corticosteroids, hydroxychloroquine, and/or immunosuppressive agents [e.g., mycophenolate mofetil])  
AND
8. IF THIS IS A NON-FORMULARY/NON-PREFERRED PRODUCT: Documentation of trial/failure of or serious side effects to a majority (not more than 3) of the preferred formulary alternatives for the given diagnosis. Documentation of medication(s) tried, dates of trial(s) and reason for treatment failure(s) is required.

MOLINA REVIEWER NOTE: For Illinois Marketplace, please see Appendix.

## CONTINUATION OF THERAPY:

### A. ACTIVE LUPUS NEPHRITIS

1. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history (Note: Review Rx history for compliance)  
AND
2. Documentation of member response to therapy as evidenced by both of the following [DOCUMENTATION REQUIRED]:
  - (a) UPCR of  $\leq$  0.5 mg/mg  
AND
  - (b) eGFR is  $\geq$  60 mL/min/1.73 m<sup>2</sup> OR has not decreased more than 30% from baseline  
NOTE: If member has an eGFR  $<$  60 mL/min/1.73 m<sup>2</sup> and it is reduced from baseline by  $>$  30%, Lupkynis should be discontinued.  
NOTE: If the member has not experienced therapeutic benefit by 24 weeks, consider discontinuation of Lupkynis.  
AND
3. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity  
AND
4. Lupkynis (voclosporin) is being used concurrently with appropriate background immunosuppressive therapy (i.e., mycophenolate mofetil and corticosteroids)

## DURATION OF APPROVAL:

Initial authorization: 6 months, Continuation of Therapy: 12 months

MOLINA REVIEWER NOTE: For Texas Marketplace, please see Appendix.

## Drug and Biologic Coverage Criteria

### **PRESCRIBER REQUIREMENTS:**

Prescribed by or in consultation with a nephrologist or rheumatologist [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

### **AGE RESTRICTIONS:**

18 years of age and older

### **QUANTITY:**

Maximum dose 47.4 mg/day

### **PLACE OF ADMINISTRATION:**

The recommendation is that oral medications in this policy will be for pharmacy benefit coverage and patient self-administered.

## DRUG INFORMATION

### **ROUTE OF ADMINISTRATION:**

Oral

### **DRUG CLASS:**

Cyclosporine Analogs

### **FDA-APPROVED USES:**

Indicated in combination with a background immunosuppressive therapy regimen for the treatment of adult patients with active lupus nephritis

*Limitations of Use: Safety and efficacy of Lupkynis have not been established in combination with cyclophosphamide. Use of Lupkynis is not recommended in this situation.*

### **COMPENDIAL APPROVED OFF-LABELED USES:**

None

## APPENDIX

**Reserved for State specific information.** Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.

### ***State Specific Information***

#### **State Marketplace**

##### **Illinois** (Source: Illinois General Assembly)

“(215 ILCS 134/45.1) Sec. 45.1. Medical exceptions procedures required. (c) An off-formulary exception request shall not be denied if: (1) the formulary prescription drug is contraindicated; (2) the patient has tried the formulary prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submits evidence of failure or intolerance; or (3) the patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan. (d) Upon the granting of an exception request, the insurer, health plan, utilization review organization, or other entity shall authorize the coverage for the drug prescribed by the enrollee's treating health care provider, to the extent the prescribed drug is a covered drug under the policy or contract up to the quantity covered. (e) Any approval of a medical exception request made pursuant to this Section shall be honored for 12 months following the date of the approval or until renewal of the plan.”

##### **Texas** (Source: [Texas Statutes, Insurance Code](#))

##### “Sec. 1369.654. PROHIBITION ON MULTIPLE PRIOR AUTHORIZATIONS.

(a) A health benefit plan issuer that provides prescription drug benefits *may not require an enrollee to receive more than one prior authorization annually* of the prescription drug benefit for a *prescription drug prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease*.

(b) This section does not apply to:

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- (1) opioids, benzodiazepines, barbiturates, or carisoprodol;
- (2) prescription drugs that have a typical treatment period of less than 12 months;
- (3) drugs that:
  - (A) have a boxed warning assigned by the United States Food and Drug Administration for use; and
  - (B) must have specific provider assessment; or
- (4) the use of a drug approved for use by the United States Food and Drug Administration in a manner other than the approved use."

## BACKGROUND AND OTHER CONSIDERATIONS

### BACKGROUND:

The recommended starting dose of Lupkynis is 23.7 mg twice a day.

Use Lupkynis in combination with mycophenolate mofetil (MMF) and corticosteroids

Safety and efficacy of Lupkynis have not been established in combination with cyclophosphamide.

Use of Lupkynis is not recommended in this situation

Dosage of Lupkynis is based on the patient's eGFR. Modify Lupkynis dosage based on eGFR

- Assess eGFR every 2 weeks for the first month, and every 4 weeks thereafter
- If eGFR is <60 mL/min/1.73 m and reduced from baseline by >20% and <30%, reduce the dose by 7.9 mg twice a day. Reassess eGFR within 2 weeks; if eGFR is still reduced from baseline by >20%, reduce the dose again by 7.9 mg twice a day
- If eGFR is <60 mL/min/1.73 m and reduced from baseline by ≥30%, discontinue Lupkynis. Reassess eGFR within 2 weeks; consider re-initiating Lupkynis at a lower dose (7.9 mg twice a day) only if eGFR has returned to ≥80% of baseline
- For patients who had a decrease in dose due to eGFR, consider increasing the dose by 7.9 mg twice a day for each eGFR measurement that is ≥80% of baseline; do not exceed the starting dose

Monitor blood pressure every 2 weeks for the first month after initiating Lupkynis, and as clinically indicated thereafter. For patients with BP >165/105 mmHg or with hypertensive emergency, discontinue Lupkynis and initiate antihypertensive therapy.

If the patient does not experience therapeutic benefit by 24 weeks, consider discontinuation of Lupkynis.

### CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:

All other uses of Lupkynis (voclosporin) are considered experimental/investigational and therefore, will follow Molina's Off-Label policy. Contraindications to Lupkynis (voclosporin) include: Patients concomitantly using strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin), known serious or severe hypersensitivity reaction to Lupkynis or any of its excipients, avoid use in patients with severe hepatic impairment.

### OTHER SPECIAL CONSIDERATIONS:

None

## CODING/BILLING INFORMATION

**CODING DISCLAIMER.** Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim

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## Drug and Biologic Coverage Criteria

and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.

HCPCS CODE	DESCRIPTION
NA	

### AVAILABLE DOSAGE FORMS:

Lupkynis CAPS 7.9MG

### REFERENCES

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11. Rovin, B. H., Ayoub, I., Tak Mao Chan, Liu, Z., Mejía-Vilet, J. M., & Jürgen Floege. (2024). KDIGO 2024 Clinical Practice Guideline for the management of LUPUS NEPHRITIS. *Kidney International*, 105(1), S1-S69. <https://doi.org/10.1016/j.kint.2023.09.002>
12. Sammaritano, L. R., Askanase, A., Bermas, B. L., Dall'Era, M., Duarte-García, A., Hiraki, L. T., ... Izmirly, P. M. (2025). 2024 American College of Rheumatology (ACR) Guideline for the Screening, Treatment, and Management of Lupus Nephritis. *Arthritis Care & Research*, 0(0). <https://doi.org/10.1002/acr.25528>

SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Required Medical Information Appendix References	Q4 2025
REVISION- Notable revisions: Coding/Billing Information Template Update	Q4 2024

## Drug and Biologic Coverage Criteria

Required Medical Information Contraindications/Exclusions/Discontinuation References	
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Available Dosage Forms	Q4 2023
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Contraindications/Exclusions/Discontinuation References	Q4 2022
Q2 2022 Established tracking in new format	Historical changes on file