PRIOR AUTHORIZATION POLICY

POLICY: Lupus – Lupkynis Prior Authorization Policy
- Lupkynis® (voclosporin capsules – Aurinia)

REVIEW DATE: 03/19/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Lupkynis, a calcineurin inhibitor immunosuppressant, is indicated in combination with a background immunosuppressive therapy regimen for the treatment of active **lupus nephritis** in adults.[1]

Limitations of Use: Lupkynis safety and efficacy have not been established in combination with cyclophosphamide and this combination is not recommended.[1]

Guidelines

Guidelines for the management of lupus nephritis from Kidney Disease: Improving Global Outcomes (KDIGO) [2024] recommend Benlysta or Lupkynis in combination with other medications plus glucocorticoids as initial treatment options for patients with active Class III or IV (± Class V) biopsy confirmed lupus nephritis (strong recommendation, moderate certainty of evidence).[3] No preference is given between the treatment protocol options; however, the KDIGO guidelines do provide individual patient clinical factors to consider, including but not limited to, kidney function and histology, risk of disease flare, proteinuria, background suppression, and need for parenteral therapy.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Lupkynis. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills

required for evaluation and diagnosis of patients treated with Lupkynis as well as the monitoring required for adverse events and long-term efficacy, approval requires Lupkynis to be prescribed by or in consultation with a physician who specializes in the condition being treated.

- **Lupkynis® (voclosporin capsules – Aurinia)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Lupus Nephritis.** Approve for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, and v):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Diagnosis of lupus nephritis has been confirmed on biopsy; AND
       Note: For example, World Health Organization class III, IV, or V lupus nephritis.
     - **iii.** The medication is being used concurrently with an immunosuppressive regimen; AND
       Note: Examples of an immunosuppressive regimen include mycophenolate mofetil or azathioprine with a systemic corticosteroid.
     - **iv.** Patient has an estimated glomerular filtration rate (eGFR) > 45 mL/min/m^2; AND
     - **v.** The medication is prescribed by or in consultation with a nephrologist or rheumatologist.
   - **B)** Patient is Currently Receiving Lupkynis. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** The medication is being used concurrently with an immunosuppressive regimen; AND
       Note: Examples of an immunosuppressive regimen include mycophenolate mofetil or azathioprine with a systemic corticosteroid.
     - **iii.** Patient has responded to Lupkynis, as determined by the prescriber; AND
       Note: Examples of a response include improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, decrease of anti-double stranded DNA (anti-dsDNA) titer, and improvement in complement levels (i.e., C3, C4).
     - **iv.** The medication is prescribed by or in consultation with a nephrologist or rheumatologist.

CONDITIONS NOT COVERED

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is(are) considered experimental, investigational or unproven for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concurrent Use with Biologics or with Cyclophosphamide.** Lupkynis has not been studied in combination with other biologics or cyclophosphamide.[1] Safety and efficacy

have not been established with these combinations. See APPENDIX for examples of biologics that should not be taken in combination with Lupkynis.

2. **Plaque Psoriasis.** In a Phase III trial, voclosporin was inferior to cyclosporine, which is an established therapy for plaque psoriasis.[4] Numerous other FDA-approved therapies are available with established efficacy for plaque psoriasis.

3. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Lupkynis® capsules [prescribing information]. Rockville, MD: Aurinia; December 2024.
2. Fanouriakis A, Kostopoulou M, Andersen J, et al. EULAR recommendations for the management of systemic lupus erythematosus: 2023 update. *Ann Rheum Dis*. 2024;83(1):15-29.
3. Kidney Disease: Improving Global Outcomes (KDIGO) Lupus Nephritis Work Group. KDIGO 2024 Clinical Practice Guideline for the management of LUPUS NEPHRITIS. *Kidney Int.* 2024;105(1S): S1-S69.
4. Li Y, Palmisano M, Sun D, Zhou Sl. Pharmacokinetic disposition difference between cyclosporine and voclosporin drives their distinct efficacy and safety profiles in clinical studies. *Clin Pharmacol*. 2020; 12:83-96.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Lupus Nephritis:** For initial therapy, a requirement was added that the patient has biopsy-confirmed lupus nephritis. For initial therapy and a patient currently taking Lupkynis, the requirement that the patient be taking mycophenolate mofetil and a corticosteroid was changed to more generally require that the patient be taking an immunosuppressive regimen. Mycophenolate mofetil or azathioprine with a systemic corticosteroid were added as examples of immunosuppressive regimens. The exception for a patient who is not a candidate for mycophenolate mofetil and a systemic corticosteroid due to inadequate efficacy or significant intolerance with these medications was removed from the policy.	03/08/2023
Selected Revision	**Lupus Nephritis:** For initial therapy, the requirement that the "Patient has autoantibody-positive systemic lupus erythematosus (SLE), defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA (anti-dsDNA) antibody" was removed from the policy.	07/05/2023
Annual Revision	No criteria changes.	03/13/2024
Annual Revision	Updated Appendix.	03/19/2025

APPENDIX

	Mechanism of Action	Examples of Indications*
Biologics		

Benlysta® (belimumab SC injection, IV infusion)	BLyS inhibitor	SLE, lupus nephritis
Saphnelo® (anifrolumab-fnia IV infusion)	IFN receptor antagonist	SLE
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
Cimzia® (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, nr-axSpA, PsO, PsA, RA
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA, RA
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
Zymfentra® (infliximab-dyyb SC injection)	Inhibition of TNF	CD, UC
Simponi®, Simponi Aria® (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
Tocilizumab Products (Actemra® IV, biosimilar; Actemra SC, biosimilar)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
Kevzara® (sarilumab SC injection)	Inhibition of IL-6	RA
Orencia® (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
Rituximab IV Products (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
Kineret® (anakinra SC injection)	Inhibition of IL-1	JIA^, RA
Omvoh® (mirikizumab IV infusion, SC injection)	Inhibition of IL-23	UC
Stelara® (ustekinumab SC injection, ustekinumab IV infusion)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
Siliq® (brodalumab SC injection)	Inhibition of IL-17	PsO
Cosentyx® (secukinumab SC injection; secukinumab IV infusion)	Inhibition of IL-17A	SC formulation: AS, ERA, nr-axSpA, PsO, PsA
		IV formulation: AS, nr-axSpA, PsA
Taltz® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Bimzelx® (bimekizumab-bkzx SC injection)	Inhibition of IL-17A/17F	PsO
Ilumya® (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
Skyrizi® (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO, UC
		IV formulation: CD, UC
Tremfya® (guselkumab SC injection, guselkumab IV infusion)	Inhibition of IL-23	SC formulation: PsA, PsO, UC
		IV formulation: UC

Entyvio® (vedolizumab IV infusion, vedolizumab SC injection)	Integrin receptor antagonist	CD, UC

* Not an all-inclusive list of indication (e.g., oncology indications and rare inflammatory conditions are not listed). Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; IV – Intravenous; BLyS – B-lymphocyte stimulator-specific inhibitor; SLE – Systemic lupus erythematosus; IFN – Interferon; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn's disease; JIA – Juvenile idiopathic arthritis; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; nr-axSpA – Non-radiographic axial spondyloarthritis; PJIA – Polyarticular juvenile idiopathic arthritis; IL – Interleukin; SJIA – Systemic juvenile idiopathic arthritis; ^ Off-label use of Kineret in JIA supported in guidelines; ERA – Enthesitis-related arthritis.