MEDICAL MUTUAL®

Drug Policy

Policy:	Lupkynis (voclosporin capsules)	Annual Review Date: 04/20/2023 Last Revised Date: 09/21/2023

OVERVIEW

Lupkynis, a calcineurin inhibitor immunosuppressant, is indicated in combination with a background immunosuppressive therapy regimen for the treatment of adults with active **lupus nephritis**.[1] Safety and efficacy have not been established in combination with cyclophosphamide and is not recommended. The recommended starting dose is 23.7 mg twice daily taken on an empty stomach, used in combination with mycophenolate mofetil and corticosteroids. Dose modifications are required based on estimated glomerular filtration rate (eGFR). Lupkynis is not recommended if baseline eGFR is ≤ 45 mL/min/1.73 m^2 unless the benefit exceeds the risk. If therapeutic benefit is not apparent by Week 24, consider discontinuation of Lupkynis.

POLICY STATEMENT

This policy involves the use of Lupkynis. Prior authorization is recommended for pharmacy benefit coverage of Lupkynis. Approval is recommended for those who meet the conditions of coverage in the **Criteria and Initial/Extended Approval** for the diagnosis provided. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

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, initial approval requires Lupkynis be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Lupkynis is recommended in those who meet the following criteria:

1. Lupus Nephritis Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve if the patient meets ALL the following conditions (i, ii, iii, iv, v and vi):
- **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.** Patient meets ONE of the following (a or b):

a) The medication is being used concurrently with mycophenolate mofetil and a systemic corticosteroid; OR
b) According to the prescriber, patient is not a candidate for mycophenolate mofetil and a systemic corticosteroid due to inadequate efficacy OR significant intolerance with these medications; AND

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 the following criteria (i, ii, iii, and iv):
i. Patient is ≥ 18 years of age; AND
ii. Patient meets ONE of the following (a or b):
a) The medication is being used concurrently with mycophenolate mofetil and a systemic corticosteroid; OR
b) According to the prescriber, patient is not a candidate for mycophenolate mofetil and a systemic corticosteroid due to inadequate efficacy OR significant intolerance with these medications; AND
iii. The medication is prescribed by or in consultation with a nephrologist or rheumatologist; AND
iv. Patient has responded to Lupkynis, as determined by the prescriber.
Note: Examples of a response include improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, and improvement in complement levels (i.e., C3, C4).

Initial Approval/ Extended Approval.
A) *Initial Approval:6 months (180 days)*
B) *Extended Approval:1 year (365 days)*

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Lupkynis has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval).

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.[3,4] 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.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not

medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Lupkynis™ capsules [prescribing information]. Rockville, MD: Aurinia; January 2021.
2. Franouriakis 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(6):713-723.
3. 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.
4. US National Institutes of Health. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2021 Jan 21]. Available from: https://clinicaltrials.gov/. Search term: voclosporin.

APPENDIX

	Mechanism of Action	Examples of Inflammatory 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
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, 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
Actemra® (tocilizumab IV infusion, tocilizumab SC injection)	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
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)	Inhibition of IL-17A	AS, ERA, nr-axSpA, PsO, PsA
Taltz® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Ilumya™ (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
Skyrizi® (risankizumab-rzza SC injection)	Inhibition of IL-23	PsA, PsO

Tremfya™ (guselkumab SC injection)	Inhibition of IL-23	PsO
Entyvio™ (vedolizumab IV infusion)	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.