

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

SAPHNELO™

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:	HCPCS Code:	

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Saphnelo™ (anifrolumab-fnia)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
MODERATE TO SEVERE SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)			
1. Does the member have a diagnosis of moderate to severe systemic lupus erythematosus (SLE)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Have laboratory tests been completed indicating the presence of autoantibodies (ANA, Anti-dsDNA, Anti-Sm, Anti-Ro/SSA, Anti-La/SSB)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the requesting provider a rheumatologist or in consultation with a rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member have a Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) score of ≥ 6 points?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does the member have a contraindication, intolerance or failure to Benlysta®?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Is the member receiving Saphnelo™ in combination with a biologic agent, Benlysta® or cyclophosphamide?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Does the member have active musculoskeletal or cutaneous disease that is unresponsive to standard therapy with glucocorticoids, antimalarials and/or other immunosuppressive agents?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

8. Does the member have corticosteroid-dependent disease (prednisone equivalent dose ≥ 7.5 mg/day) or trialed and failed both of the following: <ul style="list-style-type: none"> hydroxychloroquine AND at least 1 immunosuppressant (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide) 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
9. Is the member at least 80% compliant for at least 6 months with their baseline therapy (i.e. glucocorticoids, immunosuppressants and/or antimalarials)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
10. Will the member use Saphnelo™ concurrently with baseline therapy, unless the member has a contraindication or intolerance to all?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
11. Does the member have severe active lupus nephritis or severe active central nervous system lupus (e.g., generalized seizures, psychosis, stroke, peripheral neuropathies)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member shown a positive clinical response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member been compliant with baseline therapy during Saphnelo™ administration, unless otherwise contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the member receiving Saphnelo™ in combination with a biologic agent or Benlysta®?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does the member have severe active central nervous system lupus or severe active lupus nephritis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-M037
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.