HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
SAPHNELO™

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans 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: Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213, MHC: 844-262-1500

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)?	☐	☐	**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)?	☐	☐	**Please provide documentation**
3. Is the requesting provider a rheumatologist or in consultation with a rheumatologist?	☐	☐	**Please provide documentation**
4. Does the member have a Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) score of ≥ 6 points?	☐	☐	**Please provide documentation**
5. Does the member have a contraindication, intolerance or failure to Benlysta®?	☐	☐	**Please provide documentation**
6. Is the member receiving Saphnelo™ in combination with a biologic agent, Benlysta® or cyclophosamide?	☐	☐	**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?	☐	☐	**Please provide documentation**

8. Does the member have corticosteroid-dependent disease (prednisone equivalent dose ≥7.5mg/day) or trialed and failed both of the following: • hydroxychloroquine AND • at least 1 immunosuppressant (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide)	☐	☐	**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)?	☐	☐	**Please provide documentation**
10. Will the member use Saphnelo™ concurrently with baseline therapy, unless the member has a contraindication or intolerance to all?	☐	☐	**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)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member shown a positive clinical response to therapy?	☐	☐	**Please provide documentation**
3. Has the member been compliant with baseline therapy during Saphnelo™ administration, unless otherwise contraindicated?	☐	☐	**Please provide documentation**
4. Is the member receiving Saphnelo™ in combination with a biologic agent or Benlysta®?	☐	☐	**Please provide documentation**
5. Does the member have severe active central nervous system lupus or severe active lupus nephritis?	☐	☐	**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:			

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Policy PHARM-M037
Origination Date: 12/02/2021
Reviewed/Revised Date: 02/17/2023
Next Review Date: 02/17/2024
Current Effective Date: 03/01/2023