Excellus

Specialty Medication Review Program

Saphnelo® (anifrolumab-fnia) IV
for
Systemic Lupus Erythematosus (SLE)
(Health Professional Administered)
Medical Benefit

Complete this form and fax to:

Medical Specialty Unit
Fax #: 1-800-306-0188
Phone #: 1-800-499-1275

If you are not **buying and billing** this medication, indicate which specialty pharmacy will be used:

☐ **Accredo Health**
Fax: 1-888-773-7386
Phone: 1-866-413-4137

☐ **Walgreens Specialty Pharmacy**
Fax: 1-866-435-2173
Phone: 1-866-435-2171

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Location of Infusion:
☐ **Prescriber office** ☐ **Home/Homecare agency:**_____
☐ **Outpatient facility** ☐ **Other:** _____

Servicing Prescriber NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

Medication/Medical and Dispensing Information

Medication (HCPCS)	Dose	Frequency	Height	Weight (lbs. or kg)	Procedure Code
Saphnelo (J0491)	300mg	300mg IV once every 4 weeks			

Diagnosis/ICD-10:

1. Is this request for a: ☐ New Start ***OR*** ☐ Continuation of Therapy (Recertification) Start date: _____	☐ **Yes** ☐ **No**
2. **Recertifications Only***: Has the patient had a decrease in disease signs and symptoms while being treated with Saphnelo? (i.e., Reduction of flares) *Please submit progress notes with request	☐ **Yes** ☐ **No**
3. Will Saphnelo be used in combination with Benlysta?	☐ **Yes** ☐ **No**

Questions/Indications for Medical Necessity

**** See the Clinical Review Prior Authorization(CRPA) - Medical Policy (Pharmacy-63) for full Prior Authorization criteria ****

Does the patient have any of the following?

☐ Active Systemic Lupus Erythematosus (SLE)	☐ Severe Active Central Nervous System (CNS) lupus
☐ Severe Active Lupus Nephritis	☐ Other: _____

Systemic Lupus Erythematosus (SLE)

1. Is the prescribing physician a Rheumatologist?	☐ **Yes** ☐ **No**
2. List any presence of autoantibodies the patient has (i.e., antinuclear antibodies [ANA], anti-double stranded DNA [anti-dsDNA] antibodies, anti-Smith [anto-Sm] antibodies, etc.) a. _____ b. _____ c. _____	
3. Has the patient had a trial of standard-of-care therapy?	☐ **Yes** ☐ **No**

Provide Other Comments/Clinical Justification:

ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.

*Prescriber Signature: _____ Date: _____

I certify the above is true and accurate to the best of my knowledge.