

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Saphnelo® (anifrolumab)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Recommended Dosage: SUBQ: 120 mg once weekly

Quantity Limit: 4 injections (3.2 mL) per 28 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ☐ Member is 18 years of age or older
- ☐ Member has a diagnosis of active moderate to severe systemic lupus erythematosus (SLE)
- ☐ Member does not have severe active lupus nephritis or severe active central nervous system lupus

(Continued on next page)

- ☐ Member is currently treated with and will continue standard SLE therapy (i.e., corticosteroids, hydroxychloroquine, azathioprine, methotrexate, mycophenolate, cyclophosphamide)
- ☐ Must be prescribed by, or in consultation with, a rheumatologist or other specialist in systemic lupus erythematosus

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member continues to meet the relevant criteria identified in the initial criteria
- ☐ Member has an absence of unacceptable toxicity from the drug
- ☐ Member is being continuously monitored for a beneficial response to therapy

Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****