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: 12 months

- ❑ Prescribed by or in consultation with a rheumatologist or nephrologist
- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of autoantibody-positive SLE confirmed by **ONE** of the following **(submit lab results for documentation)**:
  - ❑ anti-nuclear antibody (ANA) titer ≥ 1:80
  - ❑ anti-double stranded DNA (anti-dsDNA) ≥ 30 IU/mL
  - ❑ anti-Smith (anti-SM) antibody levels elevated according to reference range

(Continued on next page)

- ❑ Member has active moderate to severe SLE activity as confirmed by **ONE** of the following **(submit results for documentation)**:
  - ❑ Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) score of ≥ 6
  - ❑ British Isles Lupus Assessment Group (BILAG) 2004 organ domain score of ≥ 1A or ≥ 2B
- ❑ Member has tried **THREE** of the following **(verified by chart notes or pharmacy paid claims; check all that apply)**:

❑ mycophenolate	❑ hydroxychloroquine	❑ azathioprine
❑ cyclophosphamide	❑ methotrexate	❑ cyclosporine
❑ corticosteroids	❑ Other: _____	

- ❑ Member is currently established on at least **ONE** of the following therapies taken for the last 90 days and will continue on current therapy if approved for Saphnelo™ **(verified by chart notes or pharmacy paid claims; check all that apply)**:

❑ mycophenolate	❑ hydroxychloroquine	❑ azathioprine
❑ cyclophosphamide	❑ methotrexate	❑ cyclosporine
❑ corticosteroids	❑ Other: _____	

- ❑ Saphnelo™ will **NOT** be approved for members with any of the following:
  - Severe active central nervous system lupus
  - Severe active lupus nephritis
  - Concurrent use with cyclophosphamide, voclosporin or other biologic therapies, including belimumab (Benlysta)

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 has experienced a positive clinical response to Saphnelo™ therapy as confirmed by **ONE** of the following **(submit results for documentation)**:
  - ❑ Reduction of all baseline BILAG A to B/C/D and baseline BILAG B to C/D, and no BILAG worsening in other organ systems, as defined by ≥ 1 new BILAG A or ≥ 2 new BILAG B
  - ❑ No worsening from baseline in SLEDAI-2K, where worsening is defined as an increase from baseline of > 0 points in SLEDAI-2K
- ❑ Member has an absence of intolerable side effects such as serious or recurrent infections, malignancy, severe hypersensitivity reactions/anaphylaxis or intolerable infusion reactions

(Continued on next page)

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.****

Approved by Pharmacy and Therapeutics Committee: 5/28/2026
REVISED/UPDATED/REFORMATTED: 6/15/2026