PRIOR AUTHORIZATION REQUEST

SAPHNELO SUBQ

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 9) [] Continuation (If checked, go to 2)		
2	Will the patient be taking the requested medication concomitantly with another biologic therapy, including B cell targeted therapies? [If yes, no further questions.]	Yes	No

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3	Is the patient currently receiving the requested medication? [If no, skip to question 9.]	Yes	No
4	Will the patient be on concomitant therapy with a systemic lupus erythematosus (SLE) regimen comprised of ANY of the following (alone or in combination): A) Corticosteroids, B) Antimalarials (hydroxychloroquine), C) Immunosuppressives? [If no, no further questions.]	Yes	No
5	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 9.]	Yes	No
6	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
7	Has the patient been established on therapy for at least 3 months? [If no, skip to question 9.]	Yes	No
8	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
9	Will the patient be taking the requested medication concomitantly with another biologic therapy, including B cell targeted therapies? [If yes, no further questions.]	Yes	No
10	What is the indication or diagnosis? [] Systemic Lupus Erythematosus (SLE) (If checked, go to 11) [] Lupus Nephritis (If checked, no further questions) [] Central Nervous System Lupus (If checked, no further questions) [] Other (If checked, no further questions)		
11	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
12	Does the patient have a documented diagnosis of moderately to severe systemic lupus erythematosus (SLE)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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13	Has documentation been submitted to confirm that the patient is positive for a systemic lupus erythematosus (SLE) autoantibody (e.g., anti-nuclear antibody [ANA], anti-double-stranded DNA [anti-dsDNA], anti-Smith [anti-Sm], antiribonucleoprotein [anti-RNP], anti-Ro/SSA, anti-La/SSB, antiphospholipid antibody)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Does the patient have documentation of an adequate trial and failure (of at least 3 months), intolerance, or contraindication to hydroxychloroquine at maximum tolerated dose? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Does the patient have documentation of an adequate trial and failure (of at least 3 months), intolerance, or contraindication to ALL of the following: A) Azathioprine, B) Mycophenolate, C) Methotrexate? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Will the patient be on concomitant therapy with a systemic lupus erythematosus (SLE) regimen comprised of ANY of the following (alone or in combination): A) Corticosteroids, B) Antimalarials (hydroxychloroquine), C) Immunosuppressives? [If no, no further questions.]	Yes	No
17	Does the patient have documentation of an adequate trial and failure (of at least 3 months), intolerance, or contraindication to Saphnelo IV? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions]	Yes	No
18	Does the patient have evidence of an active infection? [If yes, no further questions.]	Yes	No
19	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
20	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Note: Dosing is 120mg subcutaneously once every week.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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