Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Saphnelo
(anifrolumab-fnia)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Saphnelo 300 mg/2 mL (150 mg/mL) vial
☐ Other (please Specify): ICD10:

Dose and Quantity: Duration of therapy: J-Code:

Is this a new start or a continuation of therapy? ☐ new start ☐ continued therapy Start Date:

(if continued therapy) Has your patient had a beneficial response to this drug? Examples of a response include reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, improvement in complement levels (C3, C4), or improvement in specific organ dysfunction (for example, musculoskeletal, blood, hematologic, vascular, others) ☐ Yes ☐ No

(if no) Please provide clinical support for the continued use of Saphnelo.

Where will this medication be obtained?
☐ US Bioservices
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Urgency:

☐ Standard

☐ Urgent
(In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

What is your patient's diagnosis?

☐ Severe Active Central Nervous System Lupus
☐ Severe Active Lupus Nephritis
☐ Systemic Lupus Erythematosus (SLE)
☐ Other (please specify):

Clinical Information:

Does the patient have documentation of a positive autoantibody test (for example, anti-nuclear antibody [ANA] greater than or equal to 1:80, anti-double-stranded DNA [anti-dsDNA] greater than or equal to 30 IU/ml, anti-Smith (anti-Sm) antibodies)?
☐ Yes ☐ No

Is the medication being used concurrently with at least ONE other standard therapy [for example, an antimalarial (for example, hydroxychloroquine), systemic corticosteroid (for example, prednisone), other immunosuppressants (for example, azathioprine, mycophenolate mofetil, methotrexate)]?
☐ Yes ☐ No

(if no) Does the patient have intolerance to standard therapy due to a significant toxicity? ☐ Yes ☐ No

Is Saphnelo being prescribed by, or in consultation with, a rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist?
☐ Yes ☐ No

(if new start) Does your patient have depression or suicidality?
☐ Yes ☐ No

(if new start) The covered alternative is brand Benlysta. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative, Benlysta?
☐ The patient tried the alternative, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient can't try the alternative because of a contraindication to this drug.
☐ Other

Besides the drug being requested, other biological drugs include Actemra, Avsola, Benlysta, Cimzia, Cosentyx, Enbrel (and its biosimilars), Entyvio, Humira (and its biosimilars), Ilumya, Inflectra, Kevzara, Kineret, Orencia, Remicade, Renflexis, Riabni, Rituxan (and its biosimilars), Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, and Truxima. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biological at this time, nor will they in the future. The requested drug is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biological, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biological.
☐ other/unknown

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another biologic to treat your patient's diagnosis.

Additional Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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