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:

**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?**

☐ Systemic Lupus Erythematosus (SLE)
☐ All Others

**Clinical Information:**

Will the requested medication be used in combination with another biologic agent (for example, Benlysta, an adalimumab product [Humira, biosimilars], Cimzia, an etanercept product [Enbrel, biosimilars], an infliximab IV product [Remicade, biosimilars], Zymfentra, Simponi [Aria or SC], a tocilizumab product [Actemra, biosimilars], Kevzara, Orencia, a rituximab IV product [Rituxan, biosimilars]), Kineret, Omvoh, an ustekinumab product [Stelara, biosimilars], Siliq, Cosentyx, Taltz, Bimzelx, Ilumya, Skyrizi, Tremfya, Entyvio)? ☐ Yes ☐ No

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

Is the medication being used concurrently with at least ONE other standard therapy for systemic lupus erythematosus (SLE)? Please Note: Examples of standard therapies for SLE include an antimalarial (for example, hydroxychloroquine), systemic corticosteroid (for example, prednisone), other immunosuppressants (for example, azathioprine, mycophenolate mofetil, methotrexate)]? ☐ Yes ☐ No

(if no) According to the prescriber, is the patient intolerant to standard therapy due to a significant toxicity? ☐ Yes ☐ No

Is the patient currently receiving Saphnelo? ☐ Yes ☐ No

(if not currently receiving) Does the patient have autoantibody-positive systemic lupus erythematosus (SLE), defined as positive for at least one of the following: antinuclear antibodies (ANA), anti-double-stranded DNA (anti-dsDNA) antibodies, or anti-Smith (anti-Sm) antibodies? Please Note: Not all patients with SLE are positive for anti-dsDNA, but most will be positive for ANA. ☐ Yes ☐ No

(if currently receiving) According to the prescriber, has the patient responded to Saphnelo? Please Note: Examples of a response include reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, improvement in complement levels (that is, C3, C4), or improvement in specific organ dysfunction (for example, musculoskeletal, blood, hematologic, vascular, others). ☐ Yes ☐ No

(if not currently receiving) Has the patient tried Benlysta (belimumab) intravenous or subcutaneous [may require prior authorization]? ☐ Yes ☐ No

(if no) Per the prescriber, does the patient have depression or suicidality?

**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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