



**NC Medicaid
Pharmacy Prior Approval Request for
Lupus Medications-
SAPHNELO**

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

Clinical Information

Initial authorization (answer questions 1-10)

1. Does the beneficiary have a diagnosis of systemic lupus erythematosus (SLE)? Yes No

2. Is the beneficiary auto-antibody positive? Yes No

3. Is the beneficiary 18 years old or older Yes No

4. Does the beneficiary have severe active central nervous system lupus or severe active lupus nephritis? Yes No

5. Is Saphnelo being prescribed by or in consultation with a rheumatologist or nephrologist? Yes No

6. Does the beneficiary have moderate to severe disease? Yes No

7. Has the beneficiary failed to respond adequately to or is unable to tolerate at least one (1) standard therapy such as anti-malarials, corticosteroids, or immunosuppressives? Yes No Please list _____

8. Does the beneficiary have a clinically significant active infection? Yes No

9. Is Saphnelo being used in combination with other biologic therapies ? Yes No

10. Is Saphnelo being used in combination with standard therapy (e.g., anti-malarials, corticosteroids, non-steroidal anti-inflammatory drugs, immunosuppressives) or are standard treatment regimens not tolerated or not beneficial? Yes No Please list _____

For re-authorization (answer questions 1-12)

11. Is there documented improvement in functional impairment compared to baseline, or sustained improvement such as 1) fewer flares that required steroid treatment; 2) lower average daily oral corticosteroid dose; 3) improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits; 4) sustained improvement in laboratory measures of lupus activity Yes No

12. Is the beneficiary absent of unacceptable toxicity from the drug (ex. of unacceptable toxicity include the following: serious infections, malignancy, severe hypersensitivity reactions/anaphylaxis, etc.) Yes No

****Please attach current progress notes documenting disease status and clinical response to the medicine.****

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to 1-800-678-3189

Pharmacy PA Call Center: 1-866-799-5318