AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Saphnelo

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___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 age 18 years 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:_____

Reauthorization: (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 measured 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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406