



Saphnelo™ (anifrolumab-fnia) Injectable Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy: Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION			
First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION	
Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION					
First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:			Phone:
Specialty (Check one): <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION	
Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____

E. PRODUCT INFORMATION
Request is for: Saphnelo (anifrolumab-fnia) Dose: _____ Frequency: _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.
Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.
For ALL Requests (clinical documentation required): <input type="checkbox"/> Yes <input type="checkbox"/> No Is this infusion request in an outpatient hospital setting? → <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g. acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? → Please provide a description of the behavioral issue or impairment: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? → Please provide a description of the condition: <input type="checkbox"/> Cardiovascular: _____ <input type="checkbox"/> Respiratory: _____ <input type="checkbox"/> Renal: _____ <input type="checkbox"/> Other: _____

Continued on next page



Saphnelo™ (anifrolumab-fnia) Injectable Medication Precertification Request

Page 2 of 2

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
--------------------	-------------------	---------------	-------------

G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Yes No Will the patient be using the requested drug in combination with other biologics?

For Initiation of Therapy (clinical documentation required):

Active systemic lupus erythematosus (SLE)

Yes No Does the patient have severe active central nervous system (CNS) lupus (including seizures that are attributed to CNS lupus, psychosis, organic brain syndrome, cerebrovascular accident, cerebritis, or CNS vasculitis requiring therapeutic intervention within 60 days before initiation of anifrolumab-fnia (Saphnelo))?

Yes No Does the patient have severe active lupus nephritis?

Yes No Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus (e.g., ANA, anti-ds DNA, anti-Sm)?

Yes No Is the patient currently receiving a stable standard treatment regimen for systemic lupus erythematosus with any of the following (alone or in combination)?

→ Please identify current treatment:

Glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone)

Antimalarials (e.g., hydroxychloroquine)

Immunosuppressives (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide)

For Continuation of Therapy (clinical documentation required):

Yes No Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition?

H. ACKNOWLEDGEMENT

Request Completed By (*Signature Required*): _____ Date: ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.