NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Lupus Medications-
SAPHNELO

UnitedHealthcare Community Plan

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 form 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 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593