

POLICY NAME	Saphnelo (anifrolumab-fnia)	POLICY #	3130P
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Criteria

Coverage Criteria

- ☐ 1.1 Diagnosis of active systemic lupus erythematosus (SLE)
- ☐ 1.2 Age 18 years or older
- ☐ 1.3 Prescribed by or with a rheumatologist (musculoskeletal doctor)
- ☐ 1.4 Documented compliance with hydroxychloroquine or chloroquine, unless contraindicated
 - Compliance defined as possession of 150-days' worth of drug in 6 months
- ☐ 1.5 Documented trial and failure of or contraindication to treatment with at least one other standard of therapy: prednisone, azathioprine, leflunomide, mycophenolate mofetil, methotrexate, NSAIDs

Exclusion Criteria – Any of the following prevents coverage

- ☐ 2.1 Saphnelo will not be covered if used in combination with Benlysta or with biologic agents
- ☐ 2.2 Member currently has severe active central nervous lupus
- ☐ 2.3 Member currently has severe active lupus nephritis