

Saphnelo (odevixibat)
Effective 05/01/2022

Plan	<input type="checkbox"/> MassHealth <input type="checkbox"/> MH UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit (NLX)		
Specialty Limitations			
Contact Information	Specialty Medications		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions			

Overview

Saphnelo (anifrolumab) is a type 1 interferon (IFN) receptor antagonist indicated for the treatment of adult patients with moderate to severe systemic lupus erythematosus (SLE), who are receiving standard therapy.

Coverage Guidelines

Authorization may be reviewed for members new to AllWays Health Partners who are currently receiving treatment with the requested medication excluding when the product is obtained as samples or via manufacturer’s patient assistance programs

OR

Authorization may be granted if the member meets all following criteria and documentation has been submitted:

Saphnelo® (anifrolumab)

1. The member has a diagnosis of systemic lupus erythematosus
2. The prescribing physician is a rheumatologist
3. The member is ≥ 18 years of age
4. ONE of the following:
 - a. Use in combination with at least ONE of the following standard of care therapeutic categories: antimalarials, corticosteroids, or immunosuppressants
 - b. Physician documented contraindication to ALL of the following standard of care therapeutic categories: Antimalarials, corticosteroids, or immunosuppressants



Continuation of Therapy

Reauthorization may be granted with physician documentation of positive clinical response as evidence by low disease activity and improvement in signs and symptoms of condition.

Limitations

1. Initial approvals and reauthorizations will be granted for: 12 months

References

1. Saphnelo [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; July 2021.
2. Fanouriakis A, Kostopoulou M, Alunno A, et al. 2019 Update of the EULAR Recommendations for the Management of Systemic Lupus Erythematosus. *Ann Rheum Dis.* 2019;78:736-745.
3. Aringer M, Costenbader K, Daikh D, et al. 2019 European League Against Rheumatism/American College of Rheumatology classification criteria for systemic lupus erythematosus. *Ann Rheum Dis.* 2019;78:1151-1159.

Review History

03/16/2022 – Created for March P&T Effective 05/01/2022

Disclaimer

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.