Medical Policy:

Saphnelo (anifrolumab-fnia) Intravenous

POLICY NUMBER	LAST REVIEW	ORIGIN DATE
MG.MM.PH.345	February 18, 2025	December 9, 2021

The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as "EmblemHealth"), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

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Definitions

Saphnelo, a type 1 interferon (IFN) receptor antagonist, is indicated for the treatment of adults with moderate to severe systemic lupus erythematosus (SLE) who are receiving standard therapy. Efficacy has not been evaluated and is not recommended in patients with severe active lupus nephritis or severe active central nervous system lupus.

Length of Authorization

Coverage will be provided for 12 months and may be renewed.

Dosing Limits [Medical Benefit]

Approve a single dose vial (300 mg/2ml) every 4 weeks. (300 billable units (300 mg) every 4 weeks)

Guideline

I. Initial Approval Criteria

1. **Systemic Lupus Erythematosus (SLE)**

Approve if the patient meets **ALL** of the following criteria:

A. Patient is ≥ 18 years of age **AND**

B. Patient meets **ONE** of the following (i or ii) **AND**

   i. The medication is being used concurrently with at least one other standard therapy; **OR**

   ii. Patient is determined to be intolerant to standard therapy due to a significant toxicity, as determined by the prescriber.

   Note: Examples of standard therapies include an antimalarial (e.g., hydroxychloroquine), systemic corticosteroid (e.g., prednisone), and other immunosuppressants (e.g., azathioprine, mycophenolate mofetil, methotrexate).

C. The medication is prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist; **AND**

D. Will not be used concurrently with other biologics (e.g., Benlysta [belimumab intravenous infusion or subcutaneous injection], rituximab); **AND**

E. Patient does not have any of the following exclusion criteria:

   i. Severe active central nervous system lupus

   ii. Severe active lupus nephritis; **AND**

F. Patient has a confirmed diagnosis of SLE as evidenced by **ALL** of the following:

   i. Confirmed SLE classification criteria score ≥ 10* *(Note: must include clinical and immunologic domains criteria*)

   ii. Anti-nuclear antibody (ANA) titer of ≥ 1:80 measured via indirect immunofluorescence (IIF) on human epithelial (Hep-2) cells (or an equivalent ANA positive test) at least once; **AND**

G. Patient has documented active disease; **AND**

H. Physician has assessed baseline disease severity utilizing an objective measure/tool (i.e., Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI 2K), British Isles Lupus Assessment Group-2004 (BILAG 2004), and/or Physician's Global Assessment (PGA) score); **AND**

I. Patient has failed to respond adequately to at least one (1) standard therapy such as anti-malarials, corticosteroids, or immunosuppressives*

** Note: For patients already established on biologic therapy, trial and failure of standard therapy is not required*.

*Classification Criteria for Systemic Lupus Erythematosus (SLE)	
Clinical Score Δ (range: 0-39)	**Clinical Domains and Criteria**
2	**Constitutional:** Unexplained fever > 101ºF
	Hematologic:
3	White blood cell count < 4,000/mm3
4	Platelet count < 100,000/mm3 or Autoimmune hemolysis
	Neuropsychiatric:
2	Delirium
3	Psychosis
5	Primary generalized seizure or partial/focal seizure
	Mucocutaneous+:
2	Non-scarring alopecia or oral ulcers
4	Subacute cutaneous or discoid lupus
6	Acute cutaneous lupus
	Serosal:
5	Pleural or pericardial effusion
6	Acute pericarditis
	Musculoskeletal:
6	Joint involvement with either synovitis involving 2 or more joints with swelling or

	effusion OR tenderness in 2 or more joints with at least 30 minutes of morning stiffness
4 8 10	**Renal:** Proteinuria > 0.5g/24 hr by a 24-hour urine or equivalent spot urine protein-to-creatinine ratio Renal biopsy class II or V lupus nephritis Renal biopsy Class III or IV lupus nephritis
Immunologic Score Δ (range: 0-12)	**Immunologic Domains and Criteria**
2	**Presence of antiphospholipid antibodies** (i.e., positive lupus anticoagulant, positive anti-β2GP1 antibodies, and/or anti-cardiolipin antibodies at medium or high titer)
3 4	**Presence of low complement proteins (below lower limit of normal):** Low C3 OR low C4 Low C3 AND C4
6	**Presence of anti-Sm and/or anti-dsDNA antibodies**
* A web-based scoring calculator as well as further definitions of each criterion are available at: https://rheumatology.org/criteria Δ Occurrence on at least one occasion is sufficient to count toward score when all other causes have been ruled out. Count only the highest weighted score within each of the 10 domains (7 clinical and 3 immunologic) and any additional criteria within the same domain will not count. + Observed by a physician via clinical exam or photograph review	

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Φ Orphan Drug

II. Continuation Criteria:

1. **Systemic Lupus Erythematosus (SLE)**
   A. Patient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in initial criteria; **AND**
   B. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: serious infections, malignancy, severe hypersensitivity reactions/anaphylaxis, etc.; **AND**
   C. Adequate documentation of disease stability and/or improvement as indicated by one or more of the following when compared to pre-treatment baseline:
      i. Improvement in the SELENA-SLEDAI-2K; **OR**
      ii. Reduction of baseline BILAG-2004 (e.g., from A to B or from B to C/D, and no BILAG-2004 worsening in other organ systems, as defined by ≥2 new BILAG-2004 B or ≥1 new BILAG A); **OR**
      iii. No worsening (<0.30 points increase) in Physician's Global Assessment (PGA) score; **OR**
      iv. Seroconverted (negative)

Dosing/Administration

The recommended dosage is 300 mg as an intravenous infusion over a 30-minute period every 4 weeks.

Applicable Procedure Codes

Code	Description
J0491	Saphnelo 300MG/2ML Solution J0491 Injection, anifrolumab-fnia, 1 mg

Applicable NDCs

Code	Description
00310-3040-00	Solution, 300 mg/2ml, one single dose vial

ICD-10 Diagnoses

Code	Description
M32.10	Systemic lupus erythematosus, organ or system involvement unspecified
M32.11	Endocarditis in systemic lupus erythematosus
M32.12	Pericarditis in systemic lupus erythematosus
M32.13	Lung involvement in systemic lupus erythematosus
M32.14	Glomerular disease in systemic lupus erythematosus
M32.15	Tubulo-interstitial nephropathy in systemic lupus erythematosus
M32.19	Other organ or system involvement in systemic lupus erythematosus
M32.8	Other forms of systemic lupus erythematosus
M32.9	Systemic lupus erythematosus, unspecified

Revision History

Company(ies)	DATE	REVISION
EmblemHealth & ConnectiCare	2/18/2025	Annual Review: Updated length of authorization: removed: "Coverage will be provided for 6 months for initial therapy, and 1 year for continuation of treatment." Replaced with: "Coverage will be provided for 12 months and may be renewed." Initial Criteria: removed the following to reword: "A. Patient has autoantibody-positive SLE, defined as positive for at least one of the following: antinuclear antibodies (ANA), anti-double-stranded DNA (anti-dsDNA) antibodies, anti-Smith (anti-Sm) antibodies AND" Added: "Patient does not have any of the following exclusion criteria: Severe active central nervous system lupus, Severe active lupus nephritis; AND Patient has a confirmed diagnosis of SLE as evidenced by all of the following: Confirmed SLE classification criteria score ≥ 10* (Note: must include clinical and immunologic domains criteria) Anti-nuclear antibody (ANA) titer of ≥ 1:80 measured via indirect immunofluorescence (IIF) on human epithelial (Hep-2) cells (or an equivalent ANA positive test) at least once; AND Patient has documented active disease; AND Physician has assessed baseline disease severity utilizing an objective measure/tool (i.e., Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI 2K), British Isles Lupus Assessment Group-2004 (BILAG 2004), and/or Physician's Global Assessment (PGA) score); AND Patient has failed to respond adequately to at least one (1) standard therapy such as anti-malarials, corticosteroids, or immunosuppressives*; AND * Note: For patients already established on biologic therapy, trial and failure of standard therapy is not required." Added clinical classification chart. Continuation criteria: removed the following: "Patient meets ONE of the following (i or ii) AND The medication is being used concurrently with at least one other standard therapy OR Patient is determined to be intolerant to standard therapy due to a significant toxicity, as determined by the prescriber. Patient responded to Saphnelo, as determined by the prescriber AND *Note: Examples of a response include reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer, improvement in complement levels (i.e., C3, C4), or improvement in specific organ dysfunction (e.g., musculoskeletal, blood, hematologic, vascular, others).* The medication is prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist AND Will not be

		used concurrently with other biologics. (e.g., Benlysta [belimumab intravenous infusion or subcutaneous injection], rituximab)" Added the following: "Patient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in initial criteria; AND Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: serious infections, malignancy, severe hypersensitivity reactions/anaphylaxis, etc.; AND Adequate documentation of disease stability and/or improvement as indicated by one or more of the following when compared to pre-treatment baseline: Improvement in the SELENA-SLEDAI-2K; OR Reduction of baseline BILAG-2004 (e.g., from A to B or from B to C/D, and no BILAG-2004 worsening in other organ systems, as defined by ≥2 new BILAG-2004 B or ≥1 new BILAG A); OR No worsening (<0.30 points increase) in Physician's Global Assessment (PGA) score; OR Seroconverted (negative)"
EmblemHealth & ConnectiCare	1/8/2024	Annual Review: No criteria changes
EmblemHealth & ConnectiCare	5/9/2023	Annual Review: No criteria updates
EmblemHealth & ConnectiCare	1/12/2023	Transfer to new template. Removed codes C9086 and J3590. Added J0491
EmblemHealth & ConnectiCare	12/9/2021	New Policy

Appendix

	Mechanism of Action	Examples of Inflammatory Indications*
Biologics		
Benlysta® (belimumab SC injection, IV infusion)	BLyS inhibitor	SLE, lupus nephritis
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, HS, PsO, PsA, RA, UC, UV
Cimzia® (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, nr-axSpA, PsO, PsA, RA
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA, RA
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
Simponi®, Simponi® Aria™ (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
Actemra® (tocilizumab IV infusion, tocilizumab SC injection)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
Kevzara® (sarilumab SC injection)	Inhibition of IL-6	RA
Orencia® (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
Rituximab IV Products (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
Kineret® (anakinra SC injection)	Inhibition of IL-1	JIA^, RA
Stelara® (ustekinumab SC injection, ustekinumab IV infusion)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
Siliq™ (brodalumab SC injection)	Inhibition of IL-17	PsO
Cosentyx™ (secukinumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Taltz® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Ilumya™ (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO

Skyrizi™ (risankizumab-rzaa SC injection)	Inhibition of IL-23	PsO
Tremfya™ (guselkumab SC injection)	Inhibition of IL-23	PsA, PsO
Entyvio™ (vedolizumab IV infusion)	Integrin receptor antagonist	CD, UC

* Not an all-inclusive list of indications (e.g., oncology indications and less common inflammatory conditions are not listed). Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; IV – Intravenous, BLyS – B-lymphocyte stimulator-specific inhibitor; SLE – Systemic lupus erythematosus; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn's disease; JIA – Juvenile idiopathic arthritis; HS – Hidradenitis suppurativa; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; UV – Uveitis; nr-axSpA – Non-radiographic axial spondyloarthritis; IL – Interleukin; ^ Off-label use of Kineret in JIA supported in guidelines.

References

1. Saphnelo™ intravenous infusion [package insert]. Wilmington DE, AstraZeneca; July 2021. Updated July 2021. Accessed Sep 16, 2021.
2. Saphnelo™ intravenous infusion. IBM Micromedex® [database online]. Greenwood Village, CO. Truven Health Analytics. Available at: https://www.micromedexsolutions.com. Updated Sep 2, 2021. Accessed Sep 16, 2021.
3. 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(6):736-745.