Clinical Policy: Anifrolumab-fnia (Saphnelo)

Reference Number: CP.PHAR.551
Effective Date: 12.01.21
Last Review Date: 11.21
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Anifrolumab-fnia (Saphnelo™) is type I interferon (IFN) receptor antagonist.

FDA Approved Indication(s)

Saphnelo is indicated for the treatment of adult patients with moderate to severe systemic lupus erythematosus (SLE) who are receiving standard therapy.

Limitation(s) of use: The efficacy of Saphnelo has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Use of Saphnelo is not recommended in these situations.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Saphnelo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Systemic Lupus Erythematosus (must meet all)**:**

1. Diagnosis of SLE;
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. Documentation confirms that member is positive for an SLE autoantibody (e.g., anti-nuclear antibody (ANA), anti-double-stranded DNA (anti-dsDNA), anti-Smith (anti-Sm), anti-ribonucleoprotein (anti-RNP), anti-Ro/SSA, anti-La/SSB, antiphospholipid antibody);
5. Prescribed in combination with standard therapy for SLE that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g., prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate);
6. Dose does not exceed 300 mg every 4 weeks.

Approval duration:
Medicaid/HIM – 6 months
Commercial – 6 months or to member's renewal date, whichever is longer

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Systemic Lupus Erythematosus (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Prescribed in in combination with standard therapy for SLE that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g., prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate);
4. If request is for a dose increase, new dose does not exceed 300 mg every 4 weeks.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 6 months or to member's renewal date, whichever is longer

B. Other diagnoses/indications (1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

B. Autoantibody negative SLE.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ANA: anti-nuclear antibody
Anti-dsDNA: anti-double-stranded DNA
Anti-Sm: anti-Smith
DNA: deoxyribonucleic acid
FDA: Food and Drug Administration
LN: lupus nephritis
SLE: systemic lupus erythematosus

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
glucocorticoids (e.g., prednisone)	Varies	Varies
antimalarial agents (e.g., hydroxychloroquine, chloroquine)	Varies	Varies
non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate)*	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
** For LN, cyclophosphamide is also an acceptable immunosuppressant.*

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): previous anaphylaxis with anifrolumab-fnia
- Boxed warning(s): none reported

Appendix D: Autoantibody Positive Versus Negative SLE
The pivotal clinical trials for Saphnelo enrolled patients with at least one of the following:
- Positive antinuclear antibody test at screening by immunofluorescent assay (IFA) at the central laboratory with titer ≥1:80;
- Anti-dsDNA antibodies at screening elevated to above normal (including indeterminate), as per the central laboratory;
- Anti-Smith antibody at screening elevated to above normal as per the central laboratory

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
SLE	300 mg IV every 4 weeks	See dosing regimen

VI. Product Availability
Single-dose vial: 300 mg/2 mL

VII. References
1. Saphnelo Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; July 2021. Available at www.saphnelo.com. Accessed August 26, 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;0:1–10. doi:10.1136/annrheumdis-2019-215089.
3. Petri M, Orbai AM, Alarcón GS, et al. Derivation and validation of the Systemic Lupus International Collaborating Clinics classification criteria for systemic lupus erythematosus. *Arthritis Rheum.* 2012; 64:2677.
4. Gordon C, Amissah-Arthur MB, Gayed M, et al. The British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults. *Rheumatology.* 2018;57:e1-e45. doi:10.1093/rheumatology/kex286.

5. Morand EF, Furie R, Tanaka Y, et al. Trial of Anifrolumab in Active Systemic Lupus Erythematosus. N Engl J Med 2020;382:211-21.
6. Furie R, Khamashta M, Merrill JT, et al. Anifrolumab, an Anti–Interferon-a Receptor Monoclonal Antibody, in Moderate-to-Severe Systemic Lupus Erythematosus. Arthritis & Rheumatology 2017; 69(2): 376-386.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	08.26.21	11.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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