NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Insured Coverage of Anifrolumab (Saphnelo)

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

INITIAL REQUEST

1.) ☐ Adult patient with active, autoantibody positive, systemic lupus erythematosus (SLE), in addition to standard therapy, who meet **all** the following criteria:

2.) ☐ Moderate to severe SLE, defined as Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) score of at least 6:

SLEDAI-2K score: _____ Date: _____

3.) ☐ Unable to control disease while using an oral corticosteroid (OCS) dose of at least 10 mg/day of prednisone or equivalent. (Provide details below)

Please provide the following baseline information:

1.) Baseline British Isles Lupus Activity Group (BILAG) score: _____ Date: _____

2.) Medication History:

Therapies Tried		Dose	Duration of therapy	Outcome (Describe intolerance, effect, etc.)
OCS:				
Standard Therapy:				
Other:				

Exclusion Criteria

1.) Severe or unstable neuropsychiatric SLE: ☐ Yes ☐ No

2.) Active severe SLE nephritis: ☐ Yes ☐ No

RENEWAL REQUEST

Initial Renewal

1.) ☐ OCS dose decreased to ≤ 7.5 mg/day of prednisone or equivalent, or OCS dose decreased by at least 50% from baseline;

Current OCS: _____ Dose: _____

AND

2.) Reduction in disease activity measured by:

☐ Reducing the SLEDAI-2K score to 5 or less;

SLEDAI-2K score: _____ Date: _____

OR

☐ British Isles Lupus Activity Group (BILAG) improvement in organ systems and no new worsening:

British Isles Lupus Activity Group (BILAG) score: _____ Date: _____

Subsequent Renewal

☐ The initial response achieved after the first 12 months of therapy has been maintained.

PRESCRIBER NAME & ADDRESS:		
LICENCE #	PRESCRIBER SIGNATURE	DATE

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026

Please Return Form To: Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1; Fax: (902) 496-4440

04/2024

NOVA SCOTIA