

Saphnelo (anifrolumab-fnia) SC Injection
Effective 10/01/2026

Plan	☐ MassHealth UPPL ☒ Commercial/Exchange		Program Type	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit			
Specialty Limitations	N/A			
Contact Information	Medical Benefit Pharmacy Benefit	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029	
Exceptions	N/A			

Overview

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

In addition to being available as a subcutaneous injection, Saphnelo is also available in an intravenous formulation. The IV is restricted to the medical benefit. Requests for the IV will be reviewed against the Saphnelo medical benefit criteria.

Coverage Guidelines

If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted when all of the following criteria are met:

1. Diagnosis of moderate to severe systemic lupus erythematosus (SLE)
2. Member is 18 years of age or older
3. ONE of the following:
 - a. The member is receiving a standard treatment for SLE with any of the following (alone or in combination):
 - i. Glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone)
 - ii. Antimalarials (e.g., hydroxychloroquine)
 - iii. Immunosuppressants
 - b. Use of all of the following are clinically inappropriate for the member:
 - i. Glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone)
 - ii. Antimalarials (e.g., hydroxychloroquine)
 - iii. Immunosuppressants

Continuation of Therapy

Requests for reauthorization will be approved when all of the following criteria are met:

1. Member has achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months
2. The following quantity limits apply

Drug Name and Dosage ForSm	Quantity Limit
Saphnelo autoinjector	4 autoinjectors per 28 days
Saphnelo prefilled syringe	4 prefilled syringes per 28 days

References

1. Saphnelo (anfrolumab-fnia) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals, LP; April 2026.

Review History

07/15/2026 – Created and reviewed at July P&T. Effective 10/01/2026.

