



Fax Completed Form To  
1.833.404.2392

Prescriber Help Desk  
1.833.587.2012

Online

[covermymeds.com/main/  
prior-authorization-forms/](http://covermymeds.com/main/prior-authorization-forms/)

### Request for Prior Authorization SATRALIZUMAB (ENSPRYNG)

(PLEASE PRINT – ACCURACY IS  
IMPORTANT)

IA Medicaid Member ID # 	Patient name _____	DOB ____/____/____
Patient address _____ _____		
Provider NPI 	Prescriber name _____	Phone ____-____-____
Prescriber address _____ _____		Fax ____-____-____
Pharmacy name _____	Address _____ _____	Phone ____-____-____
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>		
Pharmacy NPI 	Pharmacy fax ____-____-____	NDC ____-____-____

Prior authorization (PA) is required for satralizumab (Enspryng). Payment will be considered under the following conditions:

- 1) Patient has a diagnosis of neuromyelitis optica spectrum disorder (NMOSD); and
- 2) Patient is anti-aquaporin 4 (AQP4) seropositive (attach documentation); and
- 3) Patient meets the FDA approved age and dosing; and
- 4) Patient has a history of at least 1 relapse in the previous 12 months prior to initiation of therapy; and
- 5) Patient has been tested for tuberculosis prior to the initiation of therapy and does not have active or untreated latent tuberculosis; and
- 6) Patient has been tested for hepatitis B virus (HBV) prior to the initiation of therapy and confirmed negative for active HBV; and
- 7) Is prescribed by a neurologist.

If the criteria for coverage are met, initial requests will be given for 1 year. Additional authorizations will be considered upon documentation of clinical response to therapy (i.e. a reduction in the frequency of relapse).

**Non-Preferred**

Enspryng

Strength  
\_\_\_\_\_

Dosage Instructions  
\_\_\_\_\_

Quantity  
\_\_\_\_\_

Days Supply  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_

Is patient anti-aquaporin 4 (AQP4) seropositive?  No  Yes (provide documentation)

Did patient experience a relapse in the previous 12 months prior to initiation of therapy?

No  Yes (provide relapse date) \_\_\_\_\_

Is patient established on satralizumab?  No  Yes (provide date therapy initiated): \_\_\_\_\_

Does patient have active or untreated latent tuberculosis?  No  Yes Screening Date: \_\_\_\_\_

Screening for Hepatitis B: Date: \_\_\_\_\_ Active Disease:  Yes  No



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**Request for Prior Authorization  
SATRALIZUMAB (ENSPRYNG)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Is prescriber a neurologist?  No  Yes

**Renewal Requests**

Provide documentation of clinical response to therapy (i.e. a reduction in the frequency of relapse):

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**Attach lab results and other documentation as necessary.**

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.