SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Enspryng™ (satralizumab-mwge) **(Pharmacy) (Non-Preferred)**
Neuromyelitis Optica Spectrum Disorder (NMOSD)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended dosage: Loading dose: 120 mg once every 2 weeks for 3 doses (weeks 0, 2, and 4), followed by maintenance dose: 120 mg once every 4 weeks. Maximum quantity: 120mg every 4 weeks.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization Approval: 1 year

- ❑ Member must be 18 years of age or older

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- ❑ Must has a confirmed diagnosis based on the following:
  - ❑ Member is seropositive for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMP-IgG antibodies **(must submit lab results)**
  - ❑ Member has one or more core clinical characteristics:
    - ❑ Optic neuritis
    - ❑ Acute myelitis
    - ❑ Area postrema syndrome; episode of otherwise unexplained hiccups or nausea and vomiting
    - ❑ Acute brainstem syndrome
    - ❑ Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
    - ❑ Symptomatic cerebral syndrome with NMOSD-typical brain lesions
- ❑ Alternative diagnoses have been excluded (e.g., multiple sclerosis, sarcoidosis, cancer, chronic infection)

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 11/19/2020
REVISED/UPDATED/REFORMATTED: ~~4/1/2021; 6/28/2021' 11/3/2023;~~ **8/11/2026**;