Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Enspryng (satralizumab-mwge) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Enspryng (satralizumab-mwge).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

3. Does the patient have indication of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive (NMOSD)?

   □ No □ Yes

4. Patient was found to be seropositive for aquaporin-4 (AQP4) IgG antibodies; AND

   □ No □ Yes

5. Patient has ≥ 1 core clinical characteristic (e.g., optic neuritis, acute myelitis, area postrema syndrome, acute brainstem syndrome, symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, symptomatic cerebral syndrome with NMOSD-typical brain lesions); AND

   □ No □ Yes

6. Alternative diagnoses have been excluded (e.g., multiple sclerosis, sarcoidosis, cancer, chronic infection)

   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. If no to any of the above questions, please provide any additional supporting information that should be taken into consideration:

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**