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- 6 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: Pharmacy | Community Provider Portal | Kaiser Permanente

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 start date: _____

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

Clinical Criteria:

1. Prescriber is a Neurologist,
   □ No □ Yes

2. **AND** documented neuromyelitis optica spectrum disorder (NMOSD) in patients at least 18 years of age,
   □ No □ Yes

3. **AND** AQP4 antibody seropositive,
   □ No □ Yes

4. **AND** at least one of the following:
   - Severe breakthrough relapse while on rituximab for at least 6 months not attributed to rapid steroid. Examples of severe breakthrough relapse include, but are not limited to:
     - Hospitalization for neurological deficits from NMOSD relapse (e.g., quadriparesis or paraparesis)
     - Optic neuritis severity (hand motion only or worse) confirmed by an ophthalmologist
   - Recurrent moderate breakthrough relapses after 6 month trial of rituximab in combination with maximum tolerated doses of either mycophenolate mofetil or azathioprine:
     - Mycophenolate mofetil: 1,000 to2,000 mg/day to target an absolute lymphocyte count of 1,000 to 1,500 cells/µL
     - Azathioprine: 3 mg/kg/day
   - Patient has a severe intolerance or contraindication to rituximab

   □ No □ Yes

5. **AND** if previously on tocilizumab, patient did not experience relapse
   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. Documented beneficial response to therapy (i.e. no documentation of recurrent relapses or MRI changes 3-6 months after initiation of therapy)
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

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

Prescriber Signature:	**Date:**