# ENSPRYNG
## PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

**The following documentation is REQUIRED.** Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

**What is the priority level of this request?**

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

**Today's Date:**___________________

**PATIENT AND INSURANCE INFORMATION** **Date of Service (if differs from Today's Date):** _________________

| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
|---|---|---|---|
| Patient Address: | City, State, Zip: | Patient Telephone: | |
| Member ID Number: | Group Number: | | |

**PRESCRIBER/CLINIC INFORMATION**

| Prescriber Name: | Prescriber NPI#: | Specialty: | Contact Name: |
|---|---|---|---|
| Clinic Name: | Clinic Address: | | |
| City, State, Zip: | Phone #: | Secure Fax #: | |

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient's Diagnosis:
☐ Neuromyelitis optica spectrum disorder (NMOSD)
☐ Other (ICD code plus description): ___________________________________________________

| Medication Requested: | Strength: |
|---|---|
| Dosing Schedule: | Quantity per Month: |

**For all requests:**

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
2. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify contraindication(s):_____________________________________________________________
   _____________________________________________________________
3. Is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ No
   If no, is there support for using the requested agent for the patient's age for the requested indication? ☐ Yes ☐ No
   If yes, please provide supporting information:_____________________________________________________________
   _____________________________________________________________
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., neurologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes ☐ No
5. Will the patient be using the requested agent in combination with Rituximab, Soliris, Uplizna, or Ultomiris? ☐ Yes ☐ No
   If yes, please specify agent: _____________________________________________________________
6. Does the patient have active or untreated latent tuberculosis? ☐ Yes ☐ No
7. Has the patient been screened for hepatitis B viral (HBV) infection? ☐ Yes ☐ No
8. Does the patient have an active hepatitis B viral (HBV) infection? ☐ Yes ☐ No
9. Has the patient had a previous HBV infection OR is a carrier for HBV infection? ☐ Yes ☐ No
   If yes, has the prescriber consulted with a gastroenterologist or a hepatologist before initiating and during treatment with the requested agent? ☐ Yes ☐ No

**Please continue to the next page.**

| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
|---|---|---|---|

10. Are there lab tests showing the patient is anti-aquaporin-4 (AQP4) antibody positive? ☐ Yes ☐ No

    If yes, please submit supporting lab test.

11. Has the patient had at least 1 discrete clinical attack of CNS symptoms? ☐ Yes ☐ No
12. Have alternative diagnoses (e.g., multiple sclerosis, ischemic optic neuropathy) been ruled out? ☐ Yes ☐ No
13. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max).____________________________________________________________

    ____________________________________________________________

    ____________________________________________________________

    ____________________________________________________________

**For Neuromyelitis optica spectrum disorder (NMOSD) requests:**

14. Has the patient's diagnosis been confirmed by at least ONE of the following? Select all that apply.
    - ☐ 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?

**For renewal requests:**

15. Has the patient had clinical benefit with the requested agent? ☐ Yes ☐ No
16. Has the patient had a previous HBV infection OR is a carrier for HBV infection? ☐ Yes ☐ No

    If yes, will the prescriber continue to consult with a gastroenterologist or a hepatologist during treatment with the requested agent? ☐ Yes ☐ No

**Please fax or mail this form to:**
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

**TOLL FREE**

**Phone:**
**BCBSIL: 800.285.9426**
**BCBSMT: 888.723.7443**
**BCBSNM: 800.544.1378**
**BCBSOK: 800.991.5643**
**BCBSTX: 800.289.1525**

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