Iowa Department of Human Services

Request for Prior Authorization SATRALIZUMAB (ENSPRYNG)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
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).

<u>Non-Preferred</u>

☐ 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

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

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Is prescriber a neurologist? ☐ No ☐ Yes

Renewal Requests

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

____

____

____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

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 Human Services, that the member continues to be eligible for Medicaid.*