maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Enspryng

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Neuromyelitis Optica Spectrum Disorder (NMOSD) (If checked, go to 2) [] Other (If checked, no further questions)		
2	Will the requested medication be used in combination with ANY of the following: A) Rituximab or its biosimilars, B) Soliris, C) Uplizna, D) Ocrevus, E) Actemra? [If yes, no further questions.]	Yes	No
3	Is the requested medication being prescribed by or in consultation with a neurologist? [If no, no further questions.]	Yes	No
4	Is the patient currently receiving the requested medication?	Yes	No

If you have any questions, call:
1-888-258-8250

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	[If no, skip to question 10.]		
5	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 10.]	Yes	No
6	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
7	Has the patient been established on therapy for at least 3 months? [If no, skip to question 10.]	Yes	No
8	Has documentation been submitted to confirm that the patient has had a clinical benefit from the use of the requested medication, according to the prescriber? [NOTE: Examples of clinical benefit include reduction in relapse rate, reduction in symptoms (such as, pain, fatigue, motor function), and a slowing in progression of symptoms.] [No further questions.]	Yes	No
9	Has documentation been submitted to confirm that the patient has experienced a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
11	Does the patient have a documented diagnosis of neuromyelitis optica spectrum disorder? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm a positive blood serum test for anti-aquaporin-4 antibody? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Does the patient exhibit at least ONE of the following core clinical characteristics of Neuromyelitis Optica Spectrum Disorder (NMOSD): A) Optic neuritis, B) Acute myelitis, C) Area postrema syndrome, D) Acute brainstem syndrome, E) Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, F) Symptomatic cerebral syndrome with NMOSD-typical brain lesions? [If no, no further questions.]	Yes	No
14	Does the patient have an Expanded Disability Status Score (EDSS) of less than or equal to 6.5? [If no, no further questions.]	Yes	No
15	Has documentation been submitted to confirm that the patient has an intolerance to, contraindication to, or trial and failure with Soliris? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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16	Has documentation been submitted to confirm that the patient has an intolerance to, contraindication to, or trial and failure with rituximab? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Has documentation been submitted to confirm that the patient has a history of at least one relapse in the last 12 months or two relapses in the last 2 years? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has documentation been submitted to confirm that the patient has a negative hepatitis B virus (HBV) test prior to treatment with the requested medication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Has the patient been screened for liver transaminases and latent tuberculosis (TB) prior to treatment and will continue to be monitored throughout therapy? [If no, no further questions.]	Yes	No
20	Has documentation been submitted to confirm that the patient is currently receiving or has previously had a trial and failure of at least TWO of the following systemic therapies: A) Azathioprine, B) Corticosteroid (such as prednisone, methylprednisolone) C) mycophenolate mofetil? ACTION REQUIRED: Submit supporting documentation.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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