Enspryng

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Enspryng SGM 4100-A – 10/2022.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Clinical Criteria Questions:

1. What is the diagnosis?
   - ❑ Neuromyelitis optica spectrum disorder (NMOSD)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Will the requested drug be used concomitantly with other biologics for the treatment of NMOSD?
   ❑ Yes ❑ No
4. Is the patient currently receiving treatment with the requested drug? ❑ Yes ❑ No *If No, skip to #6*
5. Has the patient demonstrated a positive response to therapy (e.g., reduction in number of relapses)?
   ACTION REQUIRED: If Yes, attach chart notes or medical record documentation supporting positive clinical response. ❑ Yes ❑ No *No further questions*
6. Is the patient anti-aquaporin-4 (AQP4) antibody positive? ***ACTION REQUIRED: If Yes, attach immunoassay confirming presence of anti-AQP4 antibody.*** ❑ Yes ❑ No
7. Does the patient exhibit at least one of the follow core clinical characteristics of NMOSD?
   - ❑ 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 magnetic resonance imaging (MRI) lesions
   - ❑ Symptomatic cerebral syndrome with NMOSD-typical brain lesions
   - ❑ None of the above

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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