Prior Authorization Request Form for
satralizumab-mwge injection **(Enspryng)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to Question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a neurologist?	☐ Yes Proceed to Question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication or diagnosis is the requested medication being prescribed?	☐ Neuromyelitis optica spectrum disorder (NMOSD) - Proceed to Question **4** ☐ Other - **STOP Coverage not approved**	
4. Is the patient aquaporin-4 (AQP4) antibody positive?	☐ Yes Proceed to Question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have clinical evidence of at least 2 documented relapses (including first attack) in the last 2 years prior to screening, AND at least one of which has occurred in the 12 months prior to screening?	☐ Yes Proceed to Question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have laboratory evidence of HBV negative and TB negative?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: