

Immunomodulators: Enspryng

Member Information

1. Member Last Name: _____ 2. First Name: _____
3. Member ID #: _____ 4. Member Date of Birth: _____ 5. Member Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days
Other _____

Clinical Information

Request for Neuromyelitis Optica Spectrum Disorder (NMOSD)

1. Does the member have a diagnosis of Neuromyelitis Optica Spectrum Disorder? Yes No
2. Is the member anti-aquaporin-4 (AQP4) antibody positive? Yes No
3. Is the member 18 years of age or older? Yes No
4. Is the member not on another injectable biologic immunomodulator? Yes No
5. Has the member been considered and screened for the presence of latent tuberculosis infection? Yes No
6. Has the member been tested with Hep B SAG and Core Ab? Yes No

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.