Immunomodulators: Neuromyelitis Optica Spectrum Disorder (NMOSD): Uplizna and Enspryng

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity per 30 Days: _____
   Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days
   ☐ Other: _____

Clinical Information

1. Is the member age 18 or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of Neuromyelitis Optica Spectrum Disorder? ☐ **Yes** ☐ **No**
3. Is the member on any other injectable immunomodulator? ☐ **Yes** ☐ **No**
4. Has the member been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
5. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
6. Is the member anti-aquaporin-4 (AQP4) antibody positive? ☐ **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.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277