AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Enspryng

Beneficiary Information

1. Beneficiary Last Name: ________________________________ 2. First Name: ________________________________
3. Beneficiary ID #: ____________________ 4. Beneficiary Date of Birth: ____________ 5. Beneficiary Gender: _________

Prescriber Information

6. Prescriber Name: _______________________________________ NPI #: _________________________
Mailing address: ______________________________________ City: _____________ State: _________ ZIP: _______
7. Requester Contact Information: ____
Name: ______________________________ Phone #: ______________________ Fax #: _______________________

Drug Information

8. Drug Name: ______________ 9. Dose: _______________ 10. Directions: ______________________________
11. Length of Therapy: __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 beneficiary have a diagnosis of Neuromyelitis Optica Spectrum Disorder? Yes___ No___
2. Is the beneficiary anti-aquaporin-4 (AQP4) antibody positive? Yes___ No___
3. Is the beneficiary 18 years of age or older? Yes___ No___
4. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
5. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
6. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___

Request for FDA Approved Diagnosis Not Listed Above:

1. Diagnosis: ____
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary 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.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406