Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Enspryng
(sartralizumab-mwge)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ICD10:
☐ Enspryng 120mg/ml syringe

Directions for use: Dose: Quantity: Duration of therapy:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Enspryng, please choose new start of therapy. ☐ new start of therapy ☐ continued therapy
(if continued therapy) Has your patient had a beneficial response to therapy with this drug (such as reduction in relapse rate, reduction in pain, fatigue, motor function, or a slowing progression in symptoms)? ☐ Yes ☐ No
(if no) Please provide clinical support for continued use of Enspryng. _____

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy** *(Cigna's nationally preferred specialty pharmacy)*
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Diagnosis related to use:
☐ neuromyelitis optica spectrum disorder (NMOSD)
☐ other *(please specify)*:

Clinical Information:
****This drug requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.****

(if NMOSD) Has the diagnosis been confirmed by a positive blood serum test for anti-aquaporin-4 antibody? ☐ Yes ☐ No

Has your patient already tried Soliris or Uplizna for neuromyelitis optica spectrum disorder? ☐ Yes ☐ No
What alternatives have been tried? Please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. _____

Did your patient try Azathioprine (generic Imuran; Azasan), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative, Azathioprine? ☐ Yes ☐ No

(if no) What is the reason your patient can not try the alternative, Azathioprine?

☐Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.

☐Patient is unable to take the alternative and requires the dosage formulation of the requested drug.

☐Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.

☐other

Please specify reason. _____

Did your patient try a Corticosteroid (like methylprednisolone/Solu-Medrol), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative, a Corticosteroid? ☐ Yes ☐ No

(if no) What is the reason your patient can not try the alternative, a Corticosteroid?

☐Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.

☐Patient is unable to take the alternative and requires the dosage formulation of the requested drug.

☐Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.

☐other

Please specify reason. _____

Did your patient try Mycophenolate mofetil (generic Cellcept), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative, Mycophenolate mofetil? ☐ Yes ☐ No

(if no) What is the reason your patient can not try the alternative, Mycophenolate mofetil?

☐Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.

☐Patient is unable to take the alternative and requires the dosage formulation of the requested drug.

☐Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.

☐other

Please specify reason. _____

Did your patient try Rituximab (Rituxan, Ruxience, or Truxima), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative, Rituximab? ☐ Yes ☐ No

(if no) What is the reason your patient can not try the alternative, Rituximab?

☐Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.

☐Patient is unable to take the alternative and requires the dosage formulation of the requested drug.

☐Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.

☐other

Please specify reason. _____

Does the patient have a history of at least one relapse (acute attack from neuromyelitis spectrum disorder) in the last 12 months OR two relapses in the last 2 years? ☐ Yes ☐ No

Is Enspryng being prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

Will the patient use Enspryng concomitantly with either Soliris or Uplizna? ☐ Yes ☐ No

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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