

Updated: 03/2024

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DMMA Approved: 03/2024

Request for Prior Authorization for Enspryng (satralizumab-mwge) and Uplizna (Inebilizumab-cdon)

Website Form — <a href="https://www.highmarkhealthoptions.com">www.highmarkhealthoptions.com</a>
Submit request via: Fax - 1-855-476-4158

All requests for Enspryng (satralizumab-mwge) and Uplizna (Inebilizumab-cdon) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

## Enspryng (satralizumab-mwge) and Uplizna (Inebilizumab-cdon) Prior Authorization Criteria:

For all requests for Enspryng (satralizumab-mwge) and Uplizna (Inebilizumab-cdon) all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Member must not have an active hepatitis B infection or active or untreated latent tuberculosis

Coverage may be provided with a <u>diagnosis</u> of Neuromyelitis Optica Spectrum Disorder (NMOSD) and the following criteria are met:

- Medication is prescribed by, or in consultation with a neurologist
- Documentation of a positive test for AQP4-IgG antibodies
- The prescriber submits documentation of baseline number of relapse(s), which occurred over the last year.
- Documentation of an Expanded Disability Status Scale (EDSS) score of  $\leq 6.5$  for Enspryng or a score of  $\leq 8$  for Uplizna (Inebilizumab-cdon)
- Must have documentation of inadequate response, contraindication or intolerance to one (1) immunosuppressant (e.g., mycophenolate mofetil, azathioprine, methotrexate) or an inadequate response, contraindication or intolerance to rituximab or any of its biosimilars
- **Initial Duration of Approval:** 12 months
- Reauthorization criteria
  - Documentation the member has experienced a decrease from baseline in the number of NMOSD relapse(s).
- Reauthorization Duration of Approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the



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**HEALTH OPTIONS**DMMA Approved: 03/2024 branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.



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ENSPRYNG (SATRALIZUMAB-MWGE) AND UPLIZNA (INEBILIZUMAB-CDON)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158

| PROVIDER INFORMATION Provider Specialty: Office Contact: Office Phone: Office Address: Office Phone: | If needed, you may call to spe  |  | entative. <b>PHONE</b> : (844) 325-625             | 51 Mon- Fri 8:00am to 7:00pm          |
|--|---------------------------------|--|--|---------------------------------------|
| Provider Specialty: Office Address: Office Phone: Office Phone: Office Fax:    MEMBER INFORMATION  |                                 | PROVIDER IN  | FORMATION  |                                       |
| Office Address:    Office Phone: Office Fax:   | Requesting Provider:            |  | NPI:   |                                       |
| Member Name:    Member ID:   Member weight:   Height:  | Provider Specialty:             |  | Office Contact:                                    |                                       |
| Member Name: DOB:  Member ID: Member weight: Height:  REQUESTED DRUG INFORMATION  Medication: Strength: Quantity: Refills:  Is the member currently receiving requested medication? Yes No Date Medication Initiated:  Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? Yes No    Billing Information   | Office Address:                 |  | Office Phone:                                      |                                       |
| Member Name:   DOB:   Member weight:   Height:   |                                 |  | Office Fax:  |                                       |
| Member Name:   DOB:   Member weight:   Height:   |                                 | MEMBER IN  | FORMATION  |                                       |
| Member ID:    REQUESTED DRUG INFORMATION   | Member Name:                    |  |  |                                       |
| Medication:    Strength:   Quantity:   Refills:  |                                 |  | Member weight:                                     | Height:                               |
| Medication:   Strength:   Quantity:   Refills:   |                                 | REQUESTED DRU                                      |  |                                       |
| Directions:  Is the member currently receiving requested medication?   | Medication:                     | REQUESTED DIC                                      |  |                                       |
| Is the member currently receiving requested medication?  Yes  No  Date Medication Initiated:  Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient?  Yes  No    Billing Information  |                                 |  |  | Refills:                              |
| Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient?  |                                 | ng requested medication? \( \subseteq \text{Ve}    |  | II.                                   |
| This medication will be billed: at a pharmacy OR medically, JCODE:  Place of Service: Hospital Provider's office Member's home Other  Place of Service Information  Name: NPI: Address: Phone:  MEDICAL HISTORY (Complete for ALL requests)  Diagnosis: CD-10: Does the member have an active hepatitis B infection or active or untreated latent tuberculosis? Yes No Is documentation of a positive test for AQP4-IgG antibodies provided? Yes No What is the member's Expanded Disability Status Scale (EDSS) score? How many relapse(s) have occurred over the last year? Has the member tried and failed or has a contraindication to an immunosuppressant or rituximab or rituximab biosimilar therapy? Yes, please list below No  CURRENT or PREVIOUS THERAPY  Medication Name Strength/ Frequency Dates of Therapy Status (Discontinued & Why / Current)  REAUTHORIZATION  |                                 |  |  |                                       |
| Billing Information This medication will be billed: at a pharmacy OR medically, JCODE: Place of Service: Hospital Provider's office Member's home Other  Place of Service Information Name: NPI: Address: Phone:  MEDICAL HISTORY (Complete for ALL requests)  Diagnosis: CD-10: Does the member have an active hepatitis B infection or active or untreated latent tuberculosis? Yes No Is documentation of a positive test for AQP4-IgG antibodies provided? Yes No What is the member's Expanded Disability Status Scale (EDSS) score? How many relapse(s) have occurred over the last year? Has the member tried and failed or has a contraindication to an immunosuppressant or rituximab or rituximab biosimilar therapy? Yes, please list below No  CURRENT or PREVIOUS THERAPY  Medication Name Strength/ Frequency Dates of Therapy Status (Discontinued & Why / Current)  REAUTHORIZATION  |                                 | or a chrome or long-term condition                 | on for which the medication ma                     | y be necessary for the fire of        |
| This medication will be billed:  at a pharmacy OR medically, JCODE:  Place of Service:  Member's nome Other  Place of Service Information  Name:  NPI:  Address:  Phone:  MEDICAL HISTORY (Complete for ALL requests)  Diagnosis:  ICD-10:  Does the member have an active hepatitis B infection or active or untreated latent tuberculosis?  Yes No  Is documentation of a positive test for AQP4-IgG antibodies provided?  Yes No  What is the member's Expanded Disability Status Scale (EDSS) score?  How many relapse(s) have occurred over the last year?  Has the member tried and failed or has a contraindication to an immunosuppressant or rituximab or rituximab biosimilar therapy?  Yes, please list below No  CURRENT or PREVIOUS THERAPY  Medication Name Strength/ Frequency Dates of Therapy Status (Discontinued & Why / Current)  REAUTHORIZATION  | the patient:                    | Pilling In   | Cormotion  |                                       |
| Place of Service:  | This medication will be billed: |  |  |                                       |
| Name:   NPI:   |                                 |  |  |                                       |
| Name: Address:    Phone:   | Place of Service.   Hospital    |  |  |                                       |
| MEDICAL HISTORY (Complete for ALL requests)  Diagnosis: ICD-10:  Does the member have an active hepatitis B infection or active or untreated latent tuberculosis?  | NJ                              | Place of Service                                   |  |                                       |
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| What is the member's Expanded Disability Status Scale (EDSS) score?  |                                 |  |  | Y L Yes L No                          |
| How many relapse(s) have occurred over the last year?  Has the member tried and failed or has a contraindication to an immunosuppressant or rituximab or rituximab biosimilar therapy? Yes, please list below No  CURRENT or PREVIOUS THERAPY  Medication Name   | -                               |  |  |                                       |
| Has the member tried and failed or has a contraindication to an immunosuppressant or rituximab or rituximab biosimilar therapy?   Yes, please list below No  CURRENT or PREVIOUS THERAPY  Medication Name Strength/ Frequency Dates of Therapy Status (Discontinued & Why / Current)  REAUTHORIZATION  |                                 |  |  |                                       |
| therapy?  Yes, please list below  No  CURRENT or PREVIOUS THERAPY  Medication Name  Strength/ Frequency  Dates of Therapy  Status (Discontinued & Why / Current)  REAUTHORIZATION  |                                 |  |  |                                       |
| Medication Name  Strength/ Frequency  Dates of Therapy  Status (Discontinued & Why / Current)  REAUTHORIZATION   |                                 |  | immunosuppressant or rituxima                      | ıb or rituximab biosimilar            |
| Medication Name  Strength/ Frequency  Dates of Therapy  Status (Discontinued & Why / Current)  REAUTHORIZATION   | therapy? Yes, please list be    |  |  |                                       |
| Medication Name Strength/ Frequency Dates of Therapy Why / Current)  REAUTHORIZATION   |                                 | CURRENT or PRE                                     | VIOUS THERAPY                                      |                                       |
| Medication Name Strength/ Frequency Dates of Therapy Why / Current)  REAUTHORIZATION   |                                 |  |  | Status (Discontinued &                |
| REAUTHORIZATION  | Medication Name                 | Strength/ Frequency                                | <b>Dates of Therapy</b>                            |                                       |
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|  |                                 |  |  | (                                     |
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|  |                                 |  |  | , and the second                      |
| Has the member experienced a decrease in the number of NMOSD relanse(s)? Ves submit documentation No   |                                 |  |  | , , , , , , , , , , , , , , , , , , , |
| Thas the member experienced a decrease in the number of twiosib relapse(s): res, submit documentation res  |                                 | REAUTHO  | RIZATION   | Way / Surrous/                        |
| SUPPORTING INFORMATION or CLINICAL RATIONALE   | Has the member experienced a    |  |  |                                       |
|  |                                 | decrease in the number of NMO                      | SD relapse(s) ?  Yes, submit                       | documentation. No                     |
|  |                                 | decrease in the number of NMO                      | SD relapse(s) ?  Yes, submit                       | documentation. No                     |
|  |                                 | decrease in the number of NMO                      | SD relapse(s) ?  Yes, submit                       | documentation. No                     |
|  |                                 | decrease in the number of NMO                      | SD relapse(s) ?  Yes, submit                       | documentation. No                     |
| Prescribing Provider Signature Date  | S                               | decrease in the number of NMO UPPORTING INFORMATIO | SD relapse(s)?  Yes, submit N or CLINICAL RATIONAL | documentation. No                     |
| Prescribing Provider Signature Date  | S                               | decrease in the number of NMO UPPORTING INFORMATIO | SD relapse(s)?  Yes, submit N or CLINICAL RATIONAL | documentation. No                     |
|  |                                 | decrease in the number of NMO                      | SD relapse(s) ?  Yes, submit                       | documentation. No                     |
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