Updated: 02/2025
PARP Approved: 03/2025

Prior Authorization Criteria

Enspryng (satralizumab-mwge) and Uplizna (inebilizumab-cdon)

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.

For all requests for Enspryng (satralizumab-mwge) and Uplizna (inebilizumab-cdon) all of the following criteria must be met in addition to the diagnosis specific criteria below:

- 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 diagnosis of Neuromyelitis Optica Spectrum Disorder (NMOSD) and the following criteria is 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 ≤ 6.5 for Enspryng or a score of ≤ 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

HIGHMARK WHOLECARE

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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 Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

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: _____ 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

Has the member experienced a decrease in the number of NMOSD relapse(s) ? ☐ Yes, submit documentation. ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date