# Enspryng

## CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

**Patient's Name:** _____ **Date**: _____
**Patient's ID:** _____ **Patient's Date of Birth:** _____
**Physician's Name:** _____
**Specialty:** _____ **NPI#:** _____
**Physician Office Telephone:** _____ **Physician Office Fax:** _____

**Referring Provider Info:** ❑ **Same as Requesting Provider**
**Name:** _____ **NPI#:** _____
**Fax:** _____ **Phone:** _____

**Rendering Provider Info:** ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
**Name:** _____ **NPI#:** _____
**Fax:** _____ **Phone:** _____

***Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.***

**Required Demographic Information:**

*Patient Weight:* _____*kg*

*Patient Height:* _____*cm*

*Please indicate the place of service for the requested drug:*

| | | |
|---|---|---|
| ❑ *Ambulatory Surgical* | ❑ *Home* | ❑ *Off Campus Outpatient Hospital* |
| ❑ *On Campus Outpatient Hospital* | ❑ *Office* | ❑ *Pharmacy* |

What is the ICD-10 code? _____

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

 CareFirst MR C26772-A Enspryng SGM 4100-A – 01/2025.

**CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062**
**Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com**

**Exception Criteria Questions:**

A. The preferred products for your patient's health plan are Ultomiris, Vyvgart and Vyvgart Hytrulo. Can the patient's treatment be switched to one of the preferred products?

❒ Yes, Ultomiris, *Please obtain Form for preferred product and submit for corresponding PA.*
❒ Yes, Vyvgart, *Please obtain Form for preferred product and submit for corresponding PA.*
❒ Yes, Vyvgart Hytrulo, *Please obtain Form for preferred product and submit for corresponding PA*
❒ No, *Continue to Question B*

B. What is the patient's diagnosis?

❒ Myasthenia Gravis, *Continue to Question C*

❒ Other, *Skip Question D*

C. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to all of the preferred products (Ultomiris, Vyvgart and Vyvgart Hytrulo)? ***Action Required***: If Yes, attach supporting chart note(s)

❒ Yes, *Continue to Clinical Criteria Questions*
❒ No, *Continue to Clinical Criteria Questions*

D. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to Ultomiris? ***Action Required***: If Yes, attach supporting chart note(s).

❒ Yes, *Continue to Clinical Criteria Questions*
❒ No, *Continue to Clinical Criteria Questions*

**Clinical Criteria Questions:**

1. What is the diagnosis?

❒ Neuromyelitis optica spectrum disorder (NMOSD), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Will the requested drug be used concomitantly with other biologics for the treatment of NMOSD?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 4*
❒ No, *Continue to 5*

4. Has the patient demonstrated a positive response to therapy (e.g., reduction in number of relapses)? ***ACTION REQUIRED***: If Yes, attach chart notes or medical record documentation supporting positive clinical response.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. Is the patient anti-aquaporin-4 (AQP4) antibody positive? ***ACTION REQUIRED***: If Yes, attach immunoassay confirming presence of anti-AQP4 antibody.
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Does the patient exhibit at least one of the follow core clinical characteristics of NMOSD? Optic neuritis, Acute myelitis, Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting), Acute brainstem syndrome, Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic magnetic resonance imaging (MRI) lesions, Symptomatic cerebral syndrome with NMOSD-typical brain lesions.

❒ Yes, *No further questions*

❒ No, *No further questions*

| **Step Therapy Override: Complete if Applicable for the state of Maryland.** | Please Circle | |
|---|---|---|
| Is the requested drug being used to treat stage four advanced metastatic cancer? | Yes | No |
| Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature? | Yes | No |
| Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? | Yes | No |
| Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? | Yes | No |
| Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days? | Yes | No |
| Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition? | Yes | No |

| **Step Therapy Override: Complete if Applicable for the state of Virginia.** | Please Circle | |
|---|---|---|
| Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? | Yes | No |
| Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature? | Yes | No |
| Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available? | Yes | No |
| Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient? | Yes | No |
| Is the preferred drug contraindicated? | Yes | No |
| Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen? | Yes | No |
| Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? | Yes | No |
| Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition? | Yes | No |

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X**_____

**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**