

Enspryng[®] Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Prov	Provider Information (required)		
Member Name:			Provider Name:	Provider Name:		
Insurance ID#:			NPI#:		Specialty:	
Date of Birth:			Office Phone:	Office Phone:		
Street Address:			Office Fax:	Office Fax:		
City:	State:	Zip:	Office Street Add	Office Street Address:		
Phone:			City:	State:	Zip:	
Medication Information (required)						
Medication Name:			Strength:	Strength: Dosage Form:		
Check if requesting brand			Directions for Use	Directions for Use:		
Check if request is for continuation of therapy						
Clinical Information (required)						
Select the diagnos	is below:					
Neuromyelitis optical disorder (NMOSD)						
Other diagnosis:		ICD	ICD-10 Code(s):			
Clinical information						
Select if the request		prescribed by or in con		f the following s	pecialists:	
Will the requested medication be used in combination with another biologic agent? U Yes U No						
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?						

Please note:

This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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