Uplizna

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ______________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: ______________________________ **NPI#:** __________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

Please indicate the place of service for the requested drug:

- ❑ *Ambulatory Surgical (POS Code 24)*
- ❑ *Home (POS Code 12)*
- ❑ *Off Campus Outpatient Hospital (POS Code 19)*
- ❑ *On Campus Outpatient Hospital (POS Code 22)*
- ❑ *Office (POS Code 11)*

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Uplizna SGM 3968-A – 08/2022.

Criteria Questions:

1. What is the diagnosis?
   ❑ Neuromyelitis optica spectrum disorder (NMOSD)
   ❑ Other ____

2. What is the ICD-10 code? _________________

3. Will the requested drug be used concomitantly with other biologics for the treatment of NMOSD? ❑ Yes ❑ No

4. Is the patient currently receiving treatment with Uplizna? ❑ Yes ❑ No *If No, skip to #6*

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

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

7. Does the patient exhibit at least one of the core clinical characteristics of NMOSD? *Indicate below.*
   ❑ 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
   ❑ None of the above

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X____

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

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Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076

Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org