WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Immunomodulators: Neuromyelitis Optica Spectrum Disorder (NMOSD) (Uplizna and Enspryng)

Beneficiary Information

1. Beneficiary Last Name: _____2. First Name: _____
3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information –
Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

1. Is the beneficiary age 18 or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of Neuromyelitis Optica Spectrum Disorder? ☐ **Yes** ☐ **No**
3. Is the beneficiary on any other injectable immunomodulator? ☐ **Yes** ☐ **No**
4. Has the beneficiary been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
5. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
6. Is the beneficiary anti-aquaporin-4 (AQP4) antibody positive? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**

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