accredo®

Prescription & Enrollment Form
Enspryng® (satralizumab-mwge)

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current patient

Patient's first name ____________________

Last name ____________________ Middle initial ____

Date of birth ____________ ❑ Male ❑ Female Last 4 digits of SSN ________

Street address ____________________ Apt # ________

City ____________________ State ________ Zip ________

Parent/guardian (if applicable) ____________________

Home phone ____________________

Cell phone ____________________

Work phone ____________________

E-mail address ____________________

Patient's primary language: ❑ English ❑ Other

If other, please specify ____________________

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company ____________________

Phone ____________________

Insured's name ____________________

Insured's employer ____________________

Relationship to patient ____________________

Identification # ____________________

Policy/group # ____________________

Prescription card: ❑ Yes ❑ No

If yes, carrier ____________________

Policy # ____________________

Group # ____________________

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date ____________ Time ________ Date medication needed ____________

Prescriber's first name ____________________

Last name ____________________

Prescriber's title ____________________

If NP or PA, under direction of Dr. ____________________

Office contact and title ____________________

Office contact e-mail ____________________

Office/clinic/institution name ____________________

Clinic/hospital affiliation ____________________

Street address ____________________ Suite # ________

City ____________________ State ________ Zip ________

Phone ____________________

Fax ____________________

NPI # ____________________ License # ____________

Deliver product to patient's home.

3 CLINICAL INFORMATION

Primary ICD-10 code: ____________________

Diagnosis

❑ G36.0 Neuromyelitis optica ❑ Other ____________________

Is the patient anti-aquaporin-4 antibody positive? ❑ Yes ❑ No ❑ Test pending

Prior NSMOD therapies tried/failed ____________________

Hep B vaccination: ❑ Yes ❑ No Date ____________

Does the patient have active Hepatitis B infection? ❑ Yes ❑ No

Hepatitis B screening:

❑ Hepatitis B surface antigen (HBsAg) results ❑ Positive ❑ Negative Date ________

❑ HB core antibody [HBcAb+] results ❑ Positive ❑ Negative Date ________

Does the patient have active or latent TB infection? ❑ Yes ❑ No

Tuberculosis screening: ❑ Positive ❑ Negative Date ________

❑ NKDA ❑ Known drug allergies ____________________

Concurrent meds ____________________

____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
Enspryng® (satralizumab-mwge)	120 mg/mL prefilled syringe	❑ **Treatment naïve:** Inject 120 mg subcutaneously at weeks 0, 2 and 4, followed by 120 mg every 4 weeks. ❑ **Restart (if 8 to <12 weeks since last dose)** Inject 120 mg subcutaneously upon restarting and at 2 weeks, followed by 120 mg every 4 weeks. ❑ **Restart (if ≥12 weeks since last dose)** Inject 120 mg subcutaneously at weeks 0, 2 and 4, followed by 120 mg every 4 weeks.	1-month supply Refills ________

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date ________ Dispense as written ____________________ Date ________ Substitution allowed ____________________

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, substitution prevention, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.412.4764.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

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