Pharmacy Drug Policy Checklist

POLICY NAME	Enspryng (satralizumab)	POLICY #	2794P

Criteria

Exclusion Criteria – Any of the following prevents coverage

☐ **2.1** Enspryng will not be approved for use in combination with Uplizna or Soliris

Coverage Criteria

☐ **1.1** Documented diagnosis of neuromyelitis optica spectrum disorder (NMOSD) with chart notes indicating the member exhibits at least one of the core clinical characteristics:

- Optic neuritis (inflammation of optic nerve)
- Acute myelitis (a type of inflammation of the spinal cord)
- Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting)
- Acute brainstem syndrome (lesions of the brain stem causing symptoms such as dizziness, vertigo, headache, facial pain, vision disturbances)
- Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions (resulting from a rare type of central nervous system lesion)
- Symptomatic cerebral syndrome with NMOSD-typical brain lesions

☐ **1.2** Documentation that the patient is anto-aquaporin-4 (AQP4) antibody positive

☐ **1.3** Ordered by a neuro-ophthalmologist or specialist in the treatment of NMOSD

☐ **1.4** Documentation that the member has been on a stable dose of immunosuppressive therapy (i.e., azathioprine, mycophenolate mofetil, oral corticosteroids, etc.)

☐ **1.5** Review of chart notes documenting diagnosis and confirming that patient has met all of the above requirements for treatment with Enspryng by both a pharmacist and a medical director