HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
SOLIRIS®, ULTOMIRIS®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Soliris® (eculizumab), ☐ Ultomiris® (ravilizumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)			
1. Is the member 18 years of age or older?	☐	☐	
2. Is the diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) confirmed via flow cytometry?	☐	☐	**Please provide documentation**
3. Is the member transfusion dependent requiring at least four transfusions in the past 12 months?	☐	☐	**Please provide documentation**
4. Does the member have a history of a major thrombotic event?	☐	☐	**Please provide documentation**
5. Does the member have high lactate dehydrogenase (LDH) activity with serum levels ≥1.5 times the upper limit of normal and have clinical symptoms?	☐	☐	**Please provide documentation**
6. Has the member had Neisseria meningitidis vaccination at least 2 weeks prior to start date?	☐	☐	**Please provide documentation**
7. Is the prescribing physician enrolled in the Soliris® or Ultomiris® Risk Evaluation and Mitigation Strategies (REMS) program?	☐	☐	
8. If the request is for Soliris®, has the member tried and failed Ultomiris®, unless contraindicated?	☐	☐	**Please provide documentation**
ATYPICAL HEMOLYTIC UREMIC SYNDROME (aHUS)			
1. Does the member have a diagnosis of Atypical Hemolytic Uremic Syndrome (aHUS)?	☐	☐	

2. Has Shiga toxin-related hemolytic uremic syndrome been ruled out?	☐	☐	**Please provide documentation**
3. Does the member have a normal ADAMTS-13 level?	☐	☐	**Please provide documentation**
4. Has the member had the Neisseria meningitidis vaccination?	☐	☐	**Please provide documentation**
5. Is the prescribing physician enrolled in Soliris® or Ultomiris® REMS program?	☐	☐	
6. If the request is for Soliris®, has the member tried and failed Ultomiris®, unless contraindicated?	☐	☐	**Please provide documentation**
NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)			
1. Is the prescribing provider a neurologist who specializes in treating NMOSD?	☐	☐	
2. Does the member have a confirmed diagnosis of NMOSD including both: • Anti-aquaphorin-4 (AQP4) positive • At least one of the core clinical characteristics	☐	☐	**Please provide documentation**
3. Has the member had at least one relapse requiring rescue therapy in the last 12 months or two or more relapses requiring rescue therapy in the last 24 months?	☐	☐	**Please provide documentation**
4. Is there documentation of an Expanded Disability Status Score (EDSS) of ≤8?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial and failure of Enspryng®, Ruxience® AND Uplizna™?	☐	☐	**Please provide documentation**
6. Is the prescribing physician enrolled in Soliris® REMS program?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. **Reauthorization of PNH treatment**: Has a clinically significant response been demonstrated (e.g. decrease in LDH from baseline, improvement in hemoglobin, or decrease in red blood cell transfusion frequency)?	☐	☐	**Please provide documentation**
3. **Reauthorization of aHUS treatment**: Has a clinically significant response been demonstrated (e.g. decrease in LDH, improvement in SCr/eGFR, increase in platelet count, or decrease in plasmapheresis frequency from baseline)?	☐	☐	**Please provide documentation**
4. **Reauthorization of gMG treatment**: Has a clinically significant response been demonstrated (e.g. MG-ADL score reduction of 2 points or more, QMG score reduction of 3 points or more)?	☐	☐	**Please provide documentation**
5. Reauthorization of NMOSD treatment: Has a clinically significant response been demonstrated (e.g. decrease in relapse rate, improvement or stabilization of symptoms associated with relapse, improvement in EDSS score)?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician’s Signature:

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Policy: PHARM-CHIP-M013
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024