HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA

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 dismissal of the request.

If you have prior authorization questions, please call for assistance: 833-404-4300

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.

Preferred/Non-Preferred/Non-Formulary

1. Preferred
    A. Ultomiris® (ravulizumab)
2. Non-Preferred
    A. Soliris® (eculizumab)
3. Non-Formulary
    A. Empaveli® (pegcetacoplan), Fabhalta® (iptacopan), PiaSky® (crovalimab-akkz), Voydeya™ (danicopan)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the requesting provider a hematologist or oncologist, or in consultation with one?	☐	☐	
2. Is the diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) confirmed by 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. Does documentation include baseline values of serum lactate dehydrogenase (LDH), hemoglobin level, and frequency of packed red blood cell transfusions?	☐	☐	**Please provide documentation**
7. Has the member had Neisseria meningitis vaccination at least 2 weeks prior to start date?	☐	☐	
8. Is the prescribing physician enrolled in the Risk Evaluation and Mitigation Strategies (REMS) program for the requested agent?	☐	☐	
9. If the request for Soliris®, has the member tried and failed Ultomiris®, unless contraindicated?	☐	☐	**Please provide documentation**
10. Will the requested therapy be used in combination with another complement inhibitor to treat PNH?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had a decrease in serum LDH from baseline?	☐	☐	**Please provide documentation**
3. Has the member had an improvement in hemoglobin level from baseline?	☐	☐	**Please provide documentation**
4. Has the member had a decrease in packed red blood cell transfusion frequency from baseline?	☐	☐	**Please provide documentation**
5. Has the member maintained meningitis vaccination in accordance to current recommendations for treatment?	☐	☐	
6. Is the member receiving a complement inhibitor in combination with another complement inhibitor?	☐	☐	
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 Signature:			

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Policy PHARM-CHIP-M048
Origination Date: 08/29/2024
Reviewed/Revised Date: 09/18/2024
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