HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

Atypical Hemolytic Uremic Syndrome

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: 833-404-4300.

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.

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

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
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**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. **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**

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: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025