

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)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has Shiga toxin-related hemolytic uremic syndrome been ruled out?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does the member have a normal ADAMTS-13 level?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member had the Neisseria meningitidis vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Is the prescribing physician enrolled in Soliris® or Ultomiris® REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
6. If the request is for Soliris®, has the member tried and failed Ultomiris®, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	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

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