

HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM SOLIRIS®, ULTOMIRIS®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) confirmed via flow cytometry?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the member transfusion dependent requiring at least four transfusions in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member have a history of a major thrombotic event?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Has the member had Neisseria meningitidis vaccination at least 2 weeks prior to start date?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Is the prescribing physician enrolled in the Soliris® or Ultomiris® Risk Evaluation and Mitigation Strategies (REMS) program?	<input type="checkbox"/>	<input type="checkbox"/>	
8. If the request is for Soliris®, has the member tried and failed Ultomiris®, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
ATYPICAL HEMOLYTIC UREMIC SYNDROME (aHUS)			
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
NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)			
1. Is the prescribing provider a neurologist who specializes in treating NMOSD?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a confirmed diagnosis of NMOSD including both: <ul style="list-style-type: none"> • Anti-aquaporin-4 (AQP4) positive • At least one of the core clinical characteristics 	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is there documentation of an Expanded Disability Status Score (EDSS) of ≤8?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member had an adequate trial and failure of Enspryng®, Ruxience® AND Uplizna™?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Is the prescribing physician enrolled in Soliris® REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	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)?	<input type="checkbox"/>	<input type="checkbox"/>	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)?	<input type="checkbox"/>	<input type="checkbox"/>	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)?	<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:

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

Policy: PHARM-HU-M013
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/13/2023
Next Review Date: 09/13/2024
Current Effective Date: 10/01/2023

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.