HEALTH PLANS
UNIVERSITY OF UTAH

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM
SOLIRIS®, ULTOMIRIS®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

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 4 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 presentation of clinical symptoms?	☐	☐	**Please provide documentation**
6. Has the patient had Neisseria meningitidis vaccination at least 2 weeks prior to start date?	☐	☐	**Please provide documentation**
7. Is the prescribing physician enrolled in the Soliris® Risk Evaluation and Mitigation Strategies (REMS) program?	☐	☐	
8. If the request is for Ultomiris®, has the member tried and failed Soliris®, 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 patient have a normal ADAMTS-13 level?	☐	☐	**Please provide documentation**
4. Has patient had the Neisseria meningitidis vaccination?	☐	☐	**Please provide documentation**
5. Is the prescribing physician enrolled in Soliris® REMS program?	☐	☐	
6. If the request is for Ultomiris®, has the member tried and failed Soliris®, unless contraindicated?	☐	☐	**Please provide documentation**
MYASTHENIA GRAVIS (gMG)			
1. Does the member have a diagnosis of Myasthenia Gravis (gMG)?	☐	☐	
2. Is the patient 18 years of age or older?	☐	☐	
3. Does the patient have a positive serologic test for anti-acetylcholine receptor (AchR) antibodies?	☐	☐	**Please provide documentation**
4. Has the patient been diagnosed with class II to IV gMG according to the Myasthenia Gravis Foundation of America?	☐	☐	**Please provide documentation**
5. Is the member's Myasthenia Gravis Activities of Daily Living (MG-ADL) score $\geq$ 6?	☐	☐	**Please provide documentation**
6. Has the member tried and failed at least two immunosuppressive therapies (e.g. methotrexate, corticosteroids, azathioprine, or cyclosporine) for a total duration of at least one year?	☐	☐	**Please provide documentation**
7. Has the patient tried and failed at least one immunosuppressive therapy and required chronic plasmapheresis or IVIG for a total duration of at least one year?	☐	☐	**Please provide documentation**
8. Has the patient had Neisseria meningitidis vaccination at least 2 weeks prior to start date?	☐	☐	**Please provide documentation**
9. Is the prescribing physician enrolled in Soliris® REMS program?	☐	☐	
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. Does documentation show that member has been vaccinated against Neisseria meningitidis?	☐	☐	**Please provide documentation**
4. Has the member had an adequate trial and failure of Ruxience® AND Uplizna™?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. **Reauthorization of PNH treatment**: Has 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 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 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 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:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 068
Origination Date: 12/29/2017
Reviewed/Revised Date: 08/19/2020
Next Review Date: 08/19/2021
Current Effective Date: 11/01/2020