

SOLIRIS (eculizumab) PRIOR AUTHORIZATION FORM

- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Soliris (eculizumab)** and **Quantity Limits/Daily Dose Limits**, accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	PA# _____				
Name of office contact: _____			Specialty: _____		
Contact's phone number: _____			State license #: _____		
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____		
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____		Suite #: _____	City/state/zip: _____		
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

CLINICAL INFORMATION

Medication requested:	<input type="checkbox"/> Soliris 10 mg/ml 30 ml vial
Dose/directions: _____	Quantity: _____ Refills: _____
Diagnosis (<i>submit documentation</i>): _____	Dx codes (<i>required</i>): _____
Soliris is included in the Department's Specialty Pharmacy Drug Program (SPDP). What Specialty Pharmacy will be used?	<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreens Specialty Pharmacy

Section A: INITIAL requests for the treatment of atypical Hemolytic Uremic Syndrome (aHUS)

1. Does the Recipient have a diagnosis of atypical hemolytic uremic syndrome?	<input type="checkbox"/> Yes <i>Submit documentation supporting the Recipient's diagnosis, such as medical history, lab results, genetic testing results, etc.</i> <input type="checkbox"/> No
2. Is Soliris being prescribed by or in consultation with a hematologist, nephrologist, or oncologist?	<input type="checkbox"/> Yes <i>If prescriber is not a specialist, submit documentation of consultation with an appropriate specialist.</i> <input type="checkbox"/> No
3. Has the Recipient received the following vaccinations? <i>Check all that apply.</i> <input type="checkbox"/> meningococcal vaccination (at least 2 weeks prior to the first dose of Soliris)? <input type="checkbox"/> pneumococcal vaccination <input type="checkbox"/> <i>if under the age of 18</i> , Haemophilus influenza (Hib) vaccination	<input type="checkbox"/> Yes <i>Submit supporting documentation.</i> <input type="checkbox"/> No

Section B: INITIAL requests for the treatment of Paroxysmal Nocturnal Hemoglobinuria (PNH)

1. Does the Recipient have a diagnosis of paroxysmal nocturnal hemoglobinuria as confirmed by flow cytometry testing?	<input type="checkbox"/> Yes <i>Submit documentation supporting the Recipient's diagnosis, include results of flow cytometry testing</i> <input type="checkbox"/> No
2. Is Soliris being prescribed by or in consultation with a hematologist or oncologist?	<input type="checkbox"/> Yes <i>If prescriber is not a specialist, submit documentation of consultation with an appropriate specialist.</i> <input type="checkbox"/> No
3. Has the Recipient received the following vaccinations? <i>Check all that apply.</i> <input type="checkbox"/> meningococcal vaccination (at least 2 weeks prior to the first dose of Soliris)? <input type="checkbox"/> pneumococcal vaccination <input type="checkbox"/> <i>if under the age of 18</i> , Haemophilus influenza (Hib) vaccination	<input type="checkbox"/> Yes <i>Submit supporting documentation.</i> <input type="checkbox"/> No

Section C: All RENEWAL requests

1. Since starting Soliris, has the Recipient tolerated the medication (no significant adverse events) and experienced a positive clinical response?	<input type="checkbox"/> Yes <i>Submit supporting documentation of Recipient's response to therapy.</i> <input type="checkbox"/> No
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PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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