

### SOLIRIS (eculizumab) PRIOR AUTHORIZATION FORM

**Complement Inhibitors and Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the DHS Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:		
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

### CLINICAL INFORMATION

<b>Medication requested:</b> <input type="checkbox"/> Soliris 10 mg/ml 30 ml vial <input type="checkbox"/> Soliris _____		Weight:	lbs / kg
Dose/directions:		Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):		Dx codes ( <i>required</i> ):	
<b>Specialty Pharmacy Drug Program:</b> Soliris is included in the DHS Specialty Pharmacy Drug Program (SPDP). What Specialty Pharmacy will be used?		<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreen's Specialty Pharmacy	
Is Soliris being prescribed by or in consultation with a specialist (e.g., hematologist/oncologist, neurologist, nephrologist)?		<input type="checkbox"/> Yes <i>Submit documentation of consultation if applicable.</i> <input type="checkbox"/> No	

### INITIAL requests

Does the beneficiary have a diagnosis of atypical hemolytic uremic syndrome, generalized myasthenia gravis, or paroxysmal nocturnal hemoglobinuria?		<input type="checkbox"/> Yes – <i>Submit documentation supporting the beneficiary's diagnosis.</i> <input type="checkbox"/> No – <i>Submit medical literature supporting the use of Soliris for the beneficiary's diagnosis.</i>	
Is the beneficiary up-to-date with the following vaccinations in accordance with ACIP recommendations? <i>Check all that apply.</i>		<input type="checkbox"/> Yes <i>Submit supporting documentation.</i> <input type="checkbox"/> No	
<input type="checkbox"/> meningococcal conjugate (MenACWY; Menactra, Menveo) <input type="checkbox"/> meningococcal serogroup B (MenB; Bexsero, Trumenba) <input type="checkbox"/> pneumococcal conjugate (PCV13; Prevnar 13) <input type="checkbox"/> pneumococcal polysaccharide (PPSV23; Pneumovax 23) <input type="checkbox"/> Haemophilus influenza (Hib) vaccination			

**For the treatment of generalized myasthenia gravis**, check all of the following that apply to the beneficiary and *submit documentation for each item*.

- Has a positive serologic test for anti-AChR antibodies
- Has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of treatment with Soliris
- Has a myasthenia gravis-specific activities of daily living scale (MG-ADL) total score ≥ 6 at initiation of treatment with Soliris
- Failed treatment over 6 months or more with 2 or more immunosuppressive therapies either in combination or as monotherapy OR has a contraindication or intolerance to immunosuppressive therapies
- Failed treatment with IVIG OR has a contraindication or intolerance to IVIG
- Failed treatment with plasma exchange OR has a contraindication or intolerance to plasma exchange

### RENEWAL requests

Since starting Soliris, has the beneficiary tolerated the medication (no significant adverse events) and experienced a positive clinical response?	<input type="checkbox"/> Yes <i>Submit supporting documentation of beneficiary'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**

<b>Prescriber Signature:</b>	<b>Date:</b>
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