

### ULTOMIRIS (ravulizumab) 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 address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary ID#:		DOB:	Phone:	Fax:

### CLINICAL INFORMATION

<b>Medication requested:</b>	<input type="checkbox"/> Ultomiris 300 mg/30 ml vial <input type="checkbox"/> Ultomiris _____	Weight:	lbs / kg
Dose/directions:	Quantity:	Refills:	
Diagnosis ( <i>submit documentation</i> ):	Dx codes ( <i>required</i> ):		

**Specialty Pharmacy Drug Program:** Ultomiris is included in the DHS Specialty Pharmacy Drug Program and is only available from one of the two DHS specialty pharmacies – **Diplomat Specialty Pharmacy**.

Is Ultomiris being prescribed by on in consultation with a hematologist or oncologist?	<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 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 Ultomiris for the beneficiary's diagnosis.</i>
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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"/> meningococcal conjugate (MenACWY; Menactra, Menveo)	<input type="checkbox"/> No	
<input type="checkbox"/> meningococcal serogroup B (MenB; Bexsero, Trumenba)		

#### RENEWAL requests

Since starting Ultomiris, 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	

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

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