BlueCross BlueShield Federal Employee Program

SOLIRIS
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Soliris (eculizumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Is the prescriber enrolled in the Soliris/biosimilar REMS program? ❑Yes ❑No
2. What is the patient's diagnosis?

❑Atypical hemolytic uremic syndrome (aHUS)

a. Does the patient have Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS)? ❑Yes ❑No

b. Will this medication be used in combination with another Prior Authorization (PA) medication for atypical hemolytic uremic syndrome (e.g., Ultomiris (ravulizumab-cwvz))? ❑Yes* ❑No

***If YES,** please specify the medication: _____

c. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a documented baseline value for serum lactate dehydrogenase (LDH)? ❑Yes ❑No

ii. Has or will the patient be vaccinated against Neisseria meningitidis at least 2 weeks prior to initiating therapy? ❑Yes ❑No*

***If NO**, is urgent Soliris therapy indicated for this patient (e.g., the risks of delaying treatment with Soliris outweigh the risk of developing a meningococcal infection)? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had a decrease in serum lactate dehydrogenase (LDH) from pretreatment baseline? ❑Yes ❑No

ii. Has the patient experienced unacceptable toxicity while on Soliris therapy? ❑Yes ❑No

❑Neuromyelitis optica spectrum disorder (NMOSD)

a. Will this medication be used in combination with another Prior Authorization (PA) C5 complement inhibitor for neuromyelitis optica spectrum disorder (NMOSD) (e.g., Ultomiris (ravulizumab-cwvz))? ❑Yes* ❑No

***If YES,** please specify the medication: _____

b. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Is the patient anti-aquaporin-4 (AQP4) antibody positive? ❑Yes ❑No

ii. Has or will the patient be vaccinated against Neisseria meningitidis at least 2 weeks prior to initiating therapy? ❑Yes ❑No*

***If NO**, is urgent Soliris therapy indicated for this patient (e.g., the risks of delaying treatment with Soliris outweighs the risk of developing a meningococcal infection)? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had fewer relapses while on Soliris therapy? ❑Yes ❑No

ii. Has the patient experienced unacceptable toxicity while on Soliris therapy? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

SOLIRIS
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Generalized myasthenia gravis (gMG)

a. Will this medication be used in combination with another Prior Authorization (PA) C5 complement inhibitor for generalized myasthenia gravis (e.g., Ultomiris (ravulizumab-cwvz))? ❑Yes* ❑No

If YES, please specify the medication: _____

b. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a positive serologic test for anti-AChR antibodies? ❑Yes ❑No

ii. What is the patient's MGFA (Myasthenia Gravis Foundation of America) clinical classification? ***Select answer below:***

❑Class I ❑Class II to IV ❑Class V ❑Unknown

iii. Does the patient have a documented baseline *MG-Activities of Daily Living (MG-ADL) total score greater than or equal to 6? ❑Yes ❑No

***MG-ADL*: http://c.peerview.com/inReview/programs/150204324/downloads/PVI_practiceaids_RMU.pdf**

iv. Has or will the patient be vaccinated against Neisseria meningitidis at least 2 weeks prior to initiating therapy? ❑Yes ❑No*

If NO, is urgent Soliris therapy indicated for this patient (e.g., the risks of delaying treatment with Soliris outweighs the risk of developing a meningococcal infection)? ❑Yes ❑No

v. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an acetylcholinesterase inhibitor? ❑Yes ❑No

vi. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one immunosuppressive therapy either in combination or as monotherapy, such as: azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, or cyclophosphamide? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Is there a documented decrease of the *MG-Activities of Daily Living (MG-ADL) total score from baseline of greater than or equal to 2 points? ❑Yes ❑No

***MG-ADL*: http://c.peerview.com/inReview/programs/150204324/downloads/PVI_practiceaids_RMU.pdf**

ii. Has the patient experienced unacceptable toxicity while on Soliris therapy? ❑Yes ❑No

❑Paroxysmal nocturnal hemoglobinuria (PHN)

a. Will this medication be used in combination with another Prior Authorization (PA) medication for paroxysmal nocturnal hemoglobinuria (e.g., Empaveli (pegcetacoplan), Fabhalta (iptacopan), Ultomiris (ravulizumab-cwvz))? ❑Yes* ❑No

If YES, please specify the medication: _____

b. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a documented baseline value for serum lactate dehydrogenase (LDH)? ❑Yes ❑No

ii. Has or will the patient be vaccinated against Neisseria meningitidis at least 2 weeks prior to initiating therapy? ❑Yes ❑No*

If NO, is urgent Soliris therapy indicated for this patient (e.g., the risks of delaying treatment with Soliris outweigh the risk of developing a meningococcal infection)? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had a decrease in serum lactate dehydrogenase (LDH) from pretreatment baseline? ❑Yes ❑No

ii. Has the patient experienced unacceptable toxicity while on Soliris therapy? ❑Yes ❑No

❑None of the above