(Revised 1/2023)

blue of california

FEP PPO PRESCRIPTION DRUG PRIOR AUTHORIZATION Soliris J1300

Plan/Medical Group Name: Blue Shield of California

Plan Phone#: (800) 633-4581

☐ **Non-Urgent-** The Federal Employee Program has a **72- hour turn-around time on medications that requires Prior Authorization** according to the Blue Cross Blue Shield Service Benefit Plan. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information **FAX TO: 844-224-0226**

☐ **Urgent Request-** Please note, scheduling issues do not meet the definition of Urgent. ***Definition of an Urgent Request:*** An imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision making might seriously jeopardize the life or health of the member. **FAX TO: 844-224-0226**

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____Weight (lb/kg):_	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name and HCPCS or CPT Code:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location: ☐ Physician's Office ☐ Outpatient Hospital Care	☐ Patient's Home ☐ Home Care Agency	☐ Long Term Care ☐ Ambulatory Infusion Center ☐ Other (explain):

PRESCRIPTION DRUG PRIOR AUTHORIZATION

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization.

1. Has the patient tried any other medications for this condition? **YES (if yes, complete below)** **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances or required under state and federal laws.

1. Has the patient been on Soliris continuously for the last 6 months, excluding samples? Please select answer below:
   ❑YES – **this is a PA renewal for CONTINUATION of therapy, please answer the questions on PAGE 3**
   ❑NO – **this is INITIATION of therapy, please answer the questions below:**
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has or will the patient be vaccinated against Neisseria meningitidis at least two 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
4. Is the prescriber enrolled in the Soliris REMS program? ❑Yes ❑No
5. What is the patient's diagnosis?
   ❑Atypical Hemolytic Uremic Syndrome (aHUS)
   a. Does the patient have a documented baseline value for serum lactate dehydrogenase (LDH)? ❑Yes ❑No
   b. Does the patient have Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS)? ❑Yes ❑No
   c. Will Soliris be used in combination with another Prior Authorization (PA) medication for atypical hemolytic uremic syndrome such as Ultomiris (ravulizumab-cwvz)? ❑Yes* ❑No
      *If YES, specify the medication: _____
   ❑Generalized Myasthenia Gravis (gMG)
   a. Does the patient have a positive serologic test for anti-AChR antibodies? ❑Yes ❑No
   b. What is the patient's MGFA (Myasthenia Gravis Foundation of America) clinical classification?
      Select classification below: ❑Class I ❑Class II to IV ❑Class V ❑Unknown
   c. If Class II to IV, 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
   d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an acetylcholinesterase inhibitor? ❑Yes ❑No
   e. 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
   f. Will Soliris be used in combination with another Prior Authorization (PA) C5 complement inhibitor for generalized myasthenia gravis such as Ultomiris (ravulizumab-cwvz)? ❑Yes* ❑No *If YES, specify the medication:_____

❑Neuromyelitis Optica Spectrum Disorder (NMOSD) a. Is the patient anti-aquaporin-4 (AQP4) antibody positive? ❑Yes ❑No
❑Paroxysmal Nocturnal Hemoglobinuria (PHN)

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

b. Will Soliris be used in combination with another Prior Authorization (PA) medication for paroxysmal nocturna hemoglobinuria such as Empaveli (pegcetacoplan) or Ultomiris (ravulizumab-cwvz)? ❑Yes* ❑No *If YES, specify the medication:

_____

❑Other diagnosis (please specify): _____

FOR CONTINUATION

1. Has the patient been on Soliris continuously for the last 6 months, excluding samples? ❑YES – **this is a PA renewal for CONTINUATION of therapy, please answer the questions below:**
2. What is the patient's diagnosis?

❑Atypical Hemolytic Uremic Syndrome (aHUS)
a. Has the patient had a decrease in serum lactate dehydrogenase (LDH) from pretreatment baseline? ❑Yes ❑No
b. Does the patient have Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS)? ❑Yes ❑No
c. Will Soliris be used in combination with another Prior Authorization (PA) medication for atypical hemolytic uremic syndrome such as Ultomiris (ravulizumab-cwvz)? ❑Yes* ❑No *If YES, specify the medication: _____
❑Generalized Myasthenia Gravis (gMG)
a. 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
b. Has the patient had fewer relapses while on Soliris therapy? ❑Yes ❑No
c. Will Soliris be used in combination with another Prior Authorization (PA) C5 complement inhibitor for generalized myasthenia gravis such as Ultomiris (ravulizumab-cwvz)? ❑Yes* ❑No
*If YES, specify the medication: _____
❑Neuromyelitis Optica Spectrum Disorder (NMOSD) a. Has the patient had fewer relapses while on Soliris? ❑Yes ❑No
❑Paroxysmal Nocturnal Hemoglobinuria (PHN)
a. Has the patient had a decrease in serum lactate dehydrogenase (LDH) from pretreatment baseline? ❑Yes ❑No
b. Will Soliris be used in combination with another Prior Authorization (PA) medication for paroxysmal nocturnal hemoglobinuria such as Empaveli (pegcetacoplan) or Ultomiris (ravulizumab-cwvz)? ❑Yes* ❑No
*If YES, specify the medication: _____
❑Other diagnosis (please specify): _____

3. Has the patient experienced unacceptable toxicity while on Soliris? ❑Yes ❑No
4. Is the prescriber enrolled in the Soliris REMS program? ❑Yes ❑N

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification:_____**Date**:_____

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____
Fax Number (_____)_____

Approved Denied Comments/Information Requested: _____