UnitedHealthcare Community Plan

Soliris - Arizona

Prior Authorization Request Form

Please complete this **entire** form and fax it to **866-940-7328**. If you have questions, please call **800-310-6826.**

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

□ Yes □ No	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Atypical hemolytic uremic syndrome (aHUS) □ Paroxysmal nocturnal hemoglobinuria (PNH) □ Generalized myasthenia gravis (gMG)
□ Yes □ No	**Is the medication prescribed by or in consultation with one of the following?** *(If yes, check which applies)* □ Hematologist □ Neurologist □ Oncologist

ATYPICAL HEMOLYTIC UREMIC SYNDROME (aHUS)

□ Yes □ No	**Is there documentation supporting the diagnosis of aHUS by ruling out both of the following: Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS) AND Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency)?**
□ Yes □ No	**Is Soliris initiated and titrated according to the U.S. FDA labeled dosing for aHUS, up to a maximum of 1200 mg every 2 weeks?**

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)

□ Yes □ No	**Is there documentation supporting the diagnosis of PNH that includes both of the following?** □ Flow cytometry analysis confirming presence of PNH clones □ Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.) *If yes, list results:*
□ Yes □ No	**Is Soliris dosed according to the U.S. FDA labeled dosing for PNH?**

GENERALIZED MYASTHENIA GRAVIS (gMG)

□ Yes □ No	**Is there submission of medical records (e.g., chart notes, laboratory values, etc.) to support the diagnosis of generalized myasthenia gravis (gMG) by a neurologist or in consultation with a neurologist?**
□ Yes □ No	**Is there submission of medical records confirming the patient has not failed a previous course of Soliris therapy?**
□ Yes □ No	**Is there submission of medical records confirming a positive serologic test for anti-AChR antibodies?**
□ Yes □ No	**Is there submission of medical records confirming one of the following?** *(If yes, check which applies)* □ History of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation □ History of positive anticholinesterase test, e.g., edrophonium chloride test □ Patient has demonstrated improvement in MG signs on oral cholinesterase inhibitors, as assessed by the treating neurologist
□ Yes □ No	**Is there submission of medical records confirming the patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy?**
□ Yes □ No	**Is there submission of medical records confirming the patient has a Myasthenia Gravis-specific Activities of Daily Living scale (MG-ADL) total score ≥ 6 at initiation of therapy?** *If yes, list MG-ADL score:*
□ Yes □ No	**Does the patient have history of failure of at least two immunosuppressive agents over the course of at least 12 months [e.g., azathioprine, methotrexate, cyclosporine, mycophenolate, etc.]?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the patient required two or more courses of plasmapheresis, plasma exchanges, and/or intravenous immune globulin for at least the previous 12 months without symptom control?** *(If yes, complete Section D above)*

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GENERALIZED MYASTHENIA GRAVIS *(continued)*	
□ Yes □ No	**Is the patient currently on a stable therapeutic dose (at least 3 to 6 months) of immunosuppressive therapy?** *(If yes, complete Section D above)*
□ Yes □ No	**Is Soliris initiated and titrated according to the U.S. FDA labeled dosing for gMG: up to a maximum of 1200 mg every 2 weeks?**
CONTINUATION OF THERAPY	
□ Yes □ No	**Is there documentation demonstrating a positive clinical response from baseline (e.g., reduction of plasma exchanges, reduction of dialysis, increased platelet count, reduction of hemolysis, increased or stabilization of hemoglobin levels, reduction in transfusions)?** *If yes, list positive response:*
□ Yes □ No	**Does submission of medical records (e.g., chart notes, laboratory tests) demonstrate a positive clinical response from baseline as demonstrated by at least all of the following?** □ Improvement and/or maintenance of at least a 3 point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline □ Reduction in signs and symptoms of myasthenia gravis □ Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Soliris *If yes, list all positive clinical responses:*

Provider Signature: _____ Date: _____