Blue Cross Blue Shield Blue Care Network of Michigan

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Medicare Plus Blue[SM] PPO and BCN Advantage[SM]
Medication Authorization Request Form
Soliris® (eculizumab) J1300

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit **bcbsm.com/providers** and log in to Provider Secured Services. Click the link for *Medical Prior Authorization*. As an alternative, you can use this form to request authorization. Complete and fax this form to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID number	**Specialty**
Date of birth Male Female	**Address**
Diagnosis (include ICD-10)	**City /State/ZIP**
Drug name	**Phone/Fax: P:** ( ) - **F:** ( ) -
Dose and quantity	**NPI**
Directions	**Contact person**
Date of services	**Contact person's Phone / ext.**

STEP 1: DISEASE STATE INFORMATION

1. Is this initiation of therapy or continuation of care? ☐ Initiation ☐ Continuation. Please specify date of last injection _____
2. Has the prescriber completed the training required through the Soliris® Risk Evaluation and Mitigation (REMS) Program? ☐ Yes ☐ No
3. What is the primary indication of Soliris? ☐ Atypical hemolytic uremic syndrome (aHUS) (go to Q13) ☐ Paroxysmal nocturnal hemoglobinuria (PNH) (go to Q4)
   ☐ Generalized Myasthenia Gravis (gMG) (go to Q7) ☐ Neuromyelitis Optica Spectrum Disorder (NMOSD) (go to Q14) ☐ Other, please list indication_____
4. Does patient have flow cytometric confirmation of PNH diagnosis? ☐ Yes. Please specify % of PNH type III red cells _____ ☐ No
5. Please select all answer(s) applied to the patient's condition.
   a. Patient had at least one transfusion in 24 months preceding Soliris. Please specify date of last transfusion _____
   b. Patient has documented history of major adverse thrombotic vascular event (e.g. venous thromboembolism (VTE) or pulmonary embolism (PE)). Please specify date of the event _____
   c. Patient has high does activity defined as a lactic dehydrogenase (LDH) level > 1.5 times the upper limit of normal. Please specify the patient's lactic dehydrogenase level _____
   d. None of the above.
6. What is patient's platelet count prior to Soliris therapy? _____mm^3
7. Does the patient have history of thymectomy within 12 months or thymoma or any other neoplasms of the thymus? ☐ Yes ☐ No
8. Is this patient diagnosed with anti-AChR antibody positive Myasthenia Gravis? ☐ Yes, please attach anti-AChR antibody test result ☐ No
9. Please select all the answer(s) applied to this patient's condition.
   a. Patient has positive edrophonium test. Please attach edrophonium test result
   b. Patient has history of clinical response to oral cholinesterase inhibitors such as pyridostigmine. Please attach clinical documents showing response to oral cholinesterase
   c. Patient has electrophysiological evidence of abnormal neuromuscular transmission by repetitive nerve stimulation (RNS) or single-fiber electromyography (STEMG). Please attach RNS or STEMG test result
   d. None of the above
10. Has this patient failed corticosteroids such as prednisone, methylprednisone or dexamethasone? ☐ Yes, please specify the name of corticosteroids patient failed_____ ☐ No
11. Has this patient tried any of the following immunosuppressive agents? Select all that apply. ☐ Azathioprine ☐ Cyclosporine ☐ Mycophenolate mofetil ☐ Methotrexate ☐ Tacrolimus
    ☐ Other. Please specify agents patient tried_____ ☐ None.
12. Has this patient tried any of the following agents? Select all that apply. ☐ Cyclophosphamide ☐ Rituximab ☐ Chronic intravenous immunoglobulin (IVIG)
    ☐ Chronic plasma exchange (PLEX) ☐ Other. Please specify agents patient tried_____ ☐ None
13. Please select all that applied to the patient's condition.
   a. Patient has hemoglobin level < 10 g/dL. Please specify patient's current hemoglobin level _____g/dL
   b. Patient has platelet count < 150,000/mm^3. Please specify patient's current platelet count _____ /mm^3
   c. Patient has documented evidence of hemolysis such as elevated lactate dehydrogenase levels, decreased haptoglobin level, or schistoytosis. Please attach clinical documents.
   d. Patient has increased serum creatinine or currently undergoing dialysis. Please specify patient's current creatinine level _____ mg/dL
14. Does the patient have an aquaporin-4 (AQP4) antibody positive test result? ☐ Yes. Please attach aquaporin-4 (AQP4) antibody positive test result. ☐ No.
15. Has the patient tried and failed rituximab or a rituximab biosimilar prior to Soliris treatment?
    ☐ Yes. Please attach clinical documents showing the treatment results of rituximab or rituximab biosimilar therapy. ☐ No
16. Has the patient tried and failed Uplizna® and/or Enspryng™ prior to Soliris treatment?
   a. Yes, patient tried and failed Uplizna. Please attach clinical documents showing the treatment result of Uplizna.
   b. Yes, patient tried and failed Enspryng. Please attach clinical documents showing the treatment result of Enspryng.
   c. Yes, patient tried and failed both Uplizna and Enspryng. Please attach clinical documents showing the treatment result of Uplizna and Enspryng.
   d. No, patient has not tried Uplizna or Enspryng.

Coverage won't be provided if the prescribing physician's signature and date aren't reflected on this document.

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's name **Physician's signature** **Date**

Step 2: Checklist	☐ Completed form ☐ Attached chart notes	☐ Attached diagnostic tests
Step 3: Submit	**Fax the completed form to 1-866-392-6465.**	

01/21/14; 10/19/2015; 11/9/2016;11/18/18; February2019,01/13/21, 2/22/2021