Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠
Medication Authorization Request Form
Ultomiris® (ravulizumab) J1303

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 this form and fax 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: ( ) -
Dose and Quantity	NPI
Directions	Contact Person
Date of Services	Contact Person's Phone / Ext.

STEP 1: DISEASE STATE INFORMATION

1. Is this request for initiation or continuation of therapy? ☐ Initiation ☐ Continuation. Date of last therapy:_____
2. Is the prescriber enrolled in the Ultomiris REMS program?? ☐ Yes ☐ No
3. What is the primary indication of Ultomiris? ☐ Paroxysmal nocturnal hemoglobinuria (PNH) (go to Q4) ☐ Atypical hemolytic uremic syndrome (aHUS) (go to Q13) ☐ Other. Please list indication. _____
4. Has the patient been vaccinated against meningococcal infection at least 14 days prior to starting therapy? ☐ Yes, please specify meningococcal vaccine trade name_____ and date of administration _____ ☐ No
5. Is urgent Ultomiris therapy indicated for this unvaccinated patient? ☐ Yes, AND patient will receive meningococcal vaccine as soon as possible. Please provide date of expected vaccination_____ ☐ Yes, but there are no plans to vaccinate the patient. Please provide rationale for not vaccinating patient ☐ No, the risks of delaying Ultomiris therapy does not outweigh the risks of developing a meningococcal infection
6. What is the percentage of PNH type III red cells in the flow cytometric test? _____%
7. What is the platelet level prior to initiating Ultomiris therapy? _____per mm^3
8. How many red blood cell transfusions has the patient had in the previous 24 months (prior to Ultomiris)? _____ transfusion(s)
9. Has the patient experienced a major adverse thrombotic vascular event (e.g. venous thromboembolism (VTE) or pulmonary embolism (PE))? ☐ Yes, please describe the major adverse thrombotic vascular event_____ ☐ No
10. Does the patient have a lactic dehydrogenase (LDH) level of ≥1.5 times the upper limit of normal? ☐ Yes, please provide patient's lactic dehydrogenase (LDH) level. _____ U/L ☐ No
11. What symptoms does the patient have? (select all that apply) ☐ Weakness ☐ Fatigue ☐ Hemoglobinuria ☐ Abdominal pain ☐ Dyspnea ☐ Dysphagia ☐ Erectile dysfunction ☐ Hemoglobin <10 g/dL ☐ A major vascular event ☐ Other, please specify other symptoms _____
12. (Continuation for PNH only) Please describe the clinical response to Ultomiris as documented in the office notes ☐ Decreased number of transfusions ☐ Decreased thromboembolic event ☐ Other, please specify other clinical response documented.
13. What is patient's current hemoglobin level? _____g/dL
14. What is patient's current platelet count? _____per mm^3
15. Does patient has documented evidence of hemolysis, such as elevated lactate dehydrogenase levels, decreased haptoglobin level, or schistocytosis? ☐ Yes. Please send clinical document showing that the patient has hemolysis ☐ No
16. Does patient have increased serum creatinine or currently undergoing dialysis? ☐ Yes. Please send patient's serum creatinine level or documentation for dialysis ☐ No
17. What is this patient's weight (in kg)? _____kg

Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

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 Signature	Date

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	

5/04/20/21, 2/18/2019