Soliris® (eculizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Soliris (eculizumab)
Loading Dose: _____ **Frequency:** _____
Maintenance Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
→ Please provide a description of the condition: ☐ Cardiovascular: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Atypical hemolytic uremic syndrome (aHUS)

☐ Yes ☐ No Is the disease caused by Shiga toxin?
→ ☐ Yes ☐ No Have tests been completed to confirm the absence of Shiga toxin?

Please indicate the ADAMTS 13 level: _____%

Generalized myasthenia gravis (gMG)

☐ Yes ☐ No Is the requested drug being used to treat a patient who is anti-acetylcholine receptor (AchR) antibody positive?

Please indicate the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification:

Please select: ☐ Class I ☐ Class II ☐ Class III ☐ Class IV ☐ Class V ☐ Unknown

Please indicate the patient's Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL): _____

☐ Yes ☐ No Has the patient had an inadequate response to at least two immunosuppressive therapies (i.e., azathioprine, cyclophosphamide, cyclosporine mycophenolate mofetil, methotrexate or tacrolimus)?
→ ☐ Yes ☐ No Has the patient experienced an inadequate response to chronic intravenous immunoglobulins (IVIG) and rituximab?

Neuromyelitis optica spectrum disorder (NMOSD)

☐ Yes ☐ No Is the patient anti-aquaporin-4 (AQP4) antibody positive?

☐ Yes ☐ No Does the patient exhibit at least one of the core clinical characteristics of NMOSD?
→ Please identify which characteristics apply: ☐ Acute myelitis ☐ Acute brainstem syndrome
☐ Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting)
☐ Optic neuritis ☐ Symptomatic cerebral syndrome with NMOSD-typical brain lesions
☐ Symptomatic narcolepsy of acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions

☐ Yes ☐ No Will the patient receive the requested drug concomitantly with other biologics for the treatment of neuromyelitis optica spectrum disorder (NMOSD)?

Paroxysmal nocturnal hemoglobinuria (PNH)

☐ Yes ☐ No Was the diagnosis of PNH confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs)?
→ Please identify how the diagnosis was established: ☐ Quantification of PNH cells
→ Please indicate the percentage of PNH cells: _____%
☐ Quantification of GPI-anchored protein deficient poly-morphonuclear cells
→ Please indicate the percentage of GPI-anchored protein deficient poly-morphonuclear cells: _____%
☐ None of the above

☐ Yes ☐ No Was flow cytometry used to demonstrate the deficiency of GPI-anchored proteins?

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

Atypical hemolytic uremic syndrome (aHUS)

☐ Yes ☐ No Did the patient demonstrate a positive response to therapy (e.g., normalization of lactate dehydrogenase (LDH) levels, platelet counts)?

Generalized myasthenia gravis (gMG)

☐ Yes ☐ No Has the patient experienced a positive response to therapy (e.g., improvement in MG-ADL score, changes compared to baseline in Quantitative Myasthenia Gravis (QMG) total score)?

Neuromyelitis Optica Spectrum Disorder (NMOSD)

☐ Yes ☐ No Has the patient experienced a positive response to therapy (e.g., reduction in number of relapses)?

☐ Yes ☐ No Will the patient receive the requested drug concomitantly with other biologics for the treatment of neuromyelitis optica spectrum disorder (NMOSD)?

Paroxysmal nocturnal hemoglobinuria (PNH)

☐ Yes ☐ No Did the patient demonstrate a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase (LDH) levels)?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.