

**Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form**



**Blue Cross
Blue Shield
Blue Care Network**
of Michigan

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

PATIENT INFORMATION

PHYSICIAN INFORMATION

Name

Name

ID Number

Specialty

D.O.B.

☐ Male ☐ Female

Address

Diagnosis

City /State/Zip

Drug Name

SOLIRIS

Phone:

Fax:

Dose and Quantity

NPI

Directions

Contact Person

Date of Service(s)

Contact Person
Phone / Ext.

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ ft _____ inches

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

☐ Yes ☐ No *If No, a prior authorization is not required through this process.*

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

☐ If primary, continue with questionset.

☐ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Site of Care:

A. At what location will the member be receiving the requested medication?

☐ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.

☐ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting. _____

☐ Other. Please specify. _____

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Criteria Questions:

1. Has the patient been on Soliris continuously for the last **4 months**, excluding samples? **Please select answer below:**
☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **Continuation section**.
☐ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. 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
3. Is the prescriber enrolled in the Soliris REMS program? ☐Yes ☐No
4. 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
***If Class II to IV**, does the patient have a documented baseline *MG-Activities of Daily Living (MG-ADL) total score equal to or greater than 6? ☐Yes ☐No
***MG-ADL:** http://c.peerview.com/inReview/programs/150204324/downloads/PVI_practiceaids_RMU.pdf
 - c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an acetylcholinesterase inhibitor? ☐Yes ☐No
 - d. 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
 - e. 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
 - b. Will this medication be used in combination with another Prior Authorization (PA) C5 complement inhibitor for neuromyelitis optica spectrum disorder (NMOSD)? ☐Yes* ☐No
***If YES**, specify the medication: _____☐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 nocturnal hemoglobinuria such as Empaveli (pegcetacoplan) or Ultomiris (ravulizumab-cwvz)? ☐Yes* ☐No
***If YES**, specify the medication: _____☐None of the above

CONTINUATION (PA RENEWAL)

Soliris (eculizumab)

1. Has the patient been on Soliris continuously for the last **4 months**, excluding samples? *Please select answer below:*

- ☐ **NO** – this is **INITIATION** of therapy, please answer the questions on **Initiation section.**
- ☐ **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. 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 therapy? ☐ Yes ☐ No
- b. Will this medication be used in combination with another Prior Authorization (PA) C5 complement inhibitor for neuromyelitis optica spectrum disorder (NMOSD) such as Ultomiris (ravulizumab-cwvz)? ☐ Yes* ☐ No

****If YES***, specify the medication: _____

☐ 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: _____

☐ None of the above

3. Has the patient experienced unacceptable toxicity while on Soliris therapy? ☐ Yes ☐ No

4. Is the prescriber enrolled in the Soliris REMS program? ☐ Yes ☐ No

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review (required)

Coverage will not be provided if the prescribing physician's signature and date are not 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	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Provide chart notes	<input type="checkbox"/> Attach test results
Step 3: Submit	By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979	By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320

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