



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Soliris

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<p>Patient Name:</p> <p>Member Number:</p> <p>Date of Birth:</p> <p>Group Number:</p> <p>Address:</p> <p>City, State, Zip:</p> <p>Member Phone:</p>	<p>Prescriber Name:</p> <p>Fax: Phone:</p> <p>Office Contact:</p> <p>NPI: State Lic ID:</p> <p>Address:</p> <p>City, State, Zip:</p>
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Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

<p>Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:</p>
<p>Q1. What is the requested duration of therapy?</p> <p style="margin-left: 20px;">6 months or less</p> <p style="margin-left: 20px;">Greater than 6 months</p>
<p>Q2. Is the patient over the age of 18?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q3. Is the prescribing physician a hematologist?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q4. Does the patient have a clinical documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)? Click on all that apply. Labs must be attached.</p> <p style="margin-left: 20px;">Flow cytometry on peripheral blood confirming a positive PNH clone (cells deficient for CD55/CD59 are considered PNH-positive cells</p> <p style="margin-left: 20px;">An increase in serum lactate dehydrogenase (LDH)</p> <p style="margin-left: 20px;">A negative Coombs' test</p>
<p>Q5. Does the patient have a baseline hemoglobin of <9 g/dL with symptoms or < 7 g/dL without symptoms? Labs (hemoglobin) must be attached.</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q6. Has the patient received at least four red cell transfusions during the previous 12 months?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q7. Has the patient been vaccinated against meningococcal infection (at least 2 weeks prior to Soliris treatment, if not previously vaccinated)?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q8. Has the patient been enrolled in the Soliris OneSource Program 1-888-Soliris (1-888-765-4747)?</p> <p style="margin-left: 20px;">Yes No</p>



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Patient Name:

Prescriber Name:

Q9. Comments:

Physician Signature

Date