ATRIO HEALTH PLANS

Complement Inhibitor

Soliris (eculizumab) J1300 is non-preferred. The preferred product is Ultomiris (ravulizumab-cwvz) 1303

Prior Authorization Step Therapy

Medicare Part B Request Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request 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. THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Complement Inhibitors PA

Drug Name(s):

SOLIRIS **ULTOMIRIS**

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives: **Ultomiris**
   - There is clinical documentation stating formulary alternatives are contraindicated.
3. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. ember does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approval will be for 12 months

FDA Indications:

Soliris, Ultomiris

- Paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis.
- Patients with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy.
- Generalized Myasthenia Gravis (gMG) who are antiacetylcholine receptor (AchR) antibody positive.
- Neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive. (Soliris only)

Off-Label Uses:

N/A

Step Therapy Drug(s) and FDA Indications:

Ultomiris is FDA approved for the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH) AND the treatment of adults and pediatric patients one month of age and older with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA).

Age Restrictions:

N/A

Other Clinical Consideration:

• Immunize patients without a history of meningococcal vaccination at least 2 weeks prior to receiving the first dose of Soliris or Ultomiris.

• If urgent therapy is indicated in an unvaccinated patient, administer meningococcal vaccine(s) as soon as possible.

Resources:

https://careweb.careguidelines.com/ed24/ac/ac04_114.htm#top

https://careweb.careguidelines.com/ed24/ac/ac_05260.htm#top