



Soliris

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at 1-844-387-1435.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **HPHC Provider ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Inpatient Hospital Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Drug Information:

Strength/Measure _____ *Units* ml Gm mg ea Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Soliris SGM - 10/2018.

CVS Caremark Prior Authorization • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-844-387-1435 • Fax: 1-844-851-0882 • www.caremark.com

Criteria Questions:

1. What is the patient's diagnosis?
 Atypical Hemolytic Uremic Syndrome (aHUS)
 Paroxysmal Nocturnal Hemoglobinuria (PNH)
 Other _____
2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Atypical Hemolytic Uremic Syndrome (aHUS)

3. Is the patient currently receiving Soliris? *If Yes, skip to #6* Yes No
4. Is the disease caused by Shiga toxin? Yes No
5. Is the ADAMTS 13 activity level above 5 percent? ***Action Required: Please attach documentation***
 Yes No
6. Has the patient demonstrated a positive response to therapy with Soliris (e.g., normalization of LDH levels, platelet counts)? Yes No

Section B: Paroxysmal nocturnal hemoglobin (PHN)

7. Is the patient currently receiving Soliris? *If Yes, skip to #10* Yes No
8. Does the patient have a deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins? ***Action Required: Please attach documentation*** Yes No
9. Has the patient's diagnosis been confirmed by flow cytometry results? ***Action Required: Please attach documentation*** Yes No
10. Has the patient demonstrated a positive response to therapy with Soliris (e.g., improvement in hemoglobin levels, normalization of LDG levels)? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____
Prescriber or Authorized Signature

Date (mm/dd/yy)

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