Medical drug benefit
Prior authorization request

WellSense HEALTH PLAN

Soliris or Ultomiris
Version20 Effective: 06/14/2023

Phone: 877-417-1822 (MassHealth)
877-417-0528 (Clarity plans)
877-417-1839 (NH Medicaid)
Fax: 866-539-7185

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient Information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Drug Request	
Please select the drug you are requesting (select **one**):	
☐ Soliris	☐ Ultomiris

Continued on next page

☐ Other (please specify):

4. Requested Dosing

Please document the requested dosing:

5. Member's weight in kg

Please document the member's weight in kg:

6. Concomitant use

Will the member be using Soliris, Ultomiris, rituximab product, Enspryng, and/or Uplizna concomitantly?

☐ Yes

☐ No

7. Diagnosis

What is the diagnosis the requested medication is being used to treat (select ONE)

☐ Atypical Hemolytic Uremic Syndrome (Proceed to Q8)

☐ Generalized Myasthenia Gravis (Proceed to Q9)

☐ Neuromyelitis Optica Spectrum Disorder (Proceed to Q10)

☐ Paroxysmal Nocturnal Hemoglobinuria (Proceed to Q12)

☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request

8. Atypical Hemolytic Uremic Syndrome

If the selected diagnosis is Atypical Hemolytic Uremic Syndrome, does the patient have Shiga toxin E. coli related hemolytic uremic syndrome?

☐ Yes

☐ No

9. Generalized Myasthenia Gravis:

If the selected diagnosis is Generalized Myasthenia Gravis, please select **all** that apply

☐ Member has confirmed anti-acetylcholine receptor antibody positive generalized myasthenia gravis

☐ Member received or is currently receiving pyridostigmine

☐ Member has had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine

☐ Member received or is currently receiving two different immunosuppressant therapies for ≥ 1 year

☐ Member had inadequate efficacy, a contraindication, or significant intolerance to two different immunosuppressant therapies (e.g. azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus, and cyclophosphamide)

☐ Member has evidence of unresolved symptoms of generalized myasthenia gravis, such as difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity

☐ Other, please specify:

10. Neuromyelitis Optica Spectrum Disorder:

If the selected diagnosis is Neuromyelitis optica spectrum disorder, please select **all** that apply

☐ Member's diagnosis was confirmed by blood serum test for anti-aquaporin-4 antibody positive

☐ Member has a history of at least 1 relapse in the last 12 months or two relapses in the last 2 years

☐ Other (please specify):

11. Neuromyelitis Optica Spectrum Disorder

If the selected diagnosis is Neuromyelitis optica spectrum disorder, please select the systemic therapies the member has tried. Please select **all** that apply:

☐ Azathioprine	☐ Corticosteroid
☐ Mycophenolate mofetil	☐ Rituximab
☐ Enspryng	☐ Uplizna

☐ Other clinical information (please specify):

12. Paroxysmal Nocturnal Hemoglobinuria

If the selected diagnosis is Paroxysmal Nocturnal Hemoglobinuria, has the diagnosis been confirmed by peripheral blood flow cytometry results that show the absence or deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins on at least two cell lineages?

☐ Yes

☐ No

13. Specialty of the Prescriber

Please indicate what specialty the prescriber is (select any that apply):

☐ Hematologist	☐ Nephrologist
☐ Neurologist	

☐ Other (please indicate what specialty below):

14. Initial or Continuing Therapy

Is the request for initial or continuing therapy?

☐ Initial (Proceed to Q17)

☐ Continuation (Proceed to Q15)

15. Continuation of Therapy – Generalized Myasthenia Gravis, Neuromyelitis Optica Spectrum Disorder, Paroxysmal Nocturnal Hemoglobinuria

Is the member continuing to get benefit, or have had clinical benefit from the use of the requested medication?

☐ Yes (Proceed to Q16)

☐ No

16. Member's Response to Therapy

Member's response to therapy (please choose all of the following that apply):

☐ Decreased transfusion requirements or transfusion independence

☐ Improvements in speech, swallowing, mobility, and respiratory function

☐ Reductions in exacerbations in myasthenia gravis

☐ Reduction in relapse rate

☐ Reduction in symptoms (e.g., pain, fatigue, motor function), and a slowing progression in symptoms

☐ Reduction in hemolysis

☐ Stabilization of hemoglobin levels

17. HCPC Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits (using the space below):

- ☐ HCPCS / Qcodes:
- ☐ Number of units:
- ☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.