Soliris® (eculizumab)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP 2

Diagnosis	☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) w/ confirmed hemolysis -Hg level: _____ -LDH level: _____ ☐ Diagnosis confirmed w/ Flow Cytometric Immunophenotyping (please attach results)	***Treatment with Soliris costs in excess of $400,000 per patient per year.** ***Soliris will only be paid for in patients with a Diagnosis of PNH that is confirmed by Flow Cytometry.**
Clinical Consideration	☐ Patient has received meningococcal vaccination (must be ≥ 2 weeks prior to Soliris Tx) IF Yes, DATE: _____ Please indicate which meningococcal vaccination was administered: ☐ Menactra (Age: 11-55) ☐ Menomune (Age <11 or >55) ☐ Patient does not have signs or symptoms of unresolved meningitis infection. ☐ Patient & Physician have been informed of "OneSource" Treatment Program: www.soliris.net or 1-888-SOLIRIS	
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Soliris® (eculizumab) Strength _____ Sig _____ Qty _____ Refills _____	
	Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

_____ _____
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk: 970-248-5034

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options.