Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Soliris
(eculizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Soliris

Dose: Frequency of therapy: Duration of therapy:

J-Code: ICD10:

Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:
Is this a new start or continuation of therapy**? If your patient has already begun treatment with drug samples, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy:
(if continued therapy) What was the start date and the date of the last dose? Please include the dosages given.

(if continued therapy) Is there documentation that your patient had a positive clinical response to therapy with Soliris (for example with PNH: stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, reductions in hemolysis; examples with MG: reduction in exacerbations, improvements in speech, swallowing, mobility, and respiratory function)?
Yes ☐ No ☐

(if no) Please provide clinical support for continued use of Soliris.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):
Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes ☐ No ☐
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is your patient's diagnosis?
☐ complement mediated hemolytic uremic syndrome (atypical hemolytic uremic syndrome, aHUS)
☐ myasthenia gravis (MG)
☐ neuromyelitis optica spectrum disorder (NMOSD, Devic disease or neuromyelitis optica [NMO])
☐ paroxysmal nocturnal hemoglobinuria (PNH)
☐ other (please specify):

Clinical Information

*****This drug requires supportive documentation (flow cytometry for PNH, chart notes, lab/test results, etc). Supportive documentation for ALL answers must be attached with this request*****

Has the patient been vaccinated against meningococcal infection (at least 2 weeks prior to treatment, if not previously vaccinated)? Yes ☐ No ☐

(if no) Is a meningococcal vaccine clinically appropriate for this patient? Yes ☐ No ☐

Will the patient use Soliris concomitantly with a rituximab product, Enspryng (satralizumab-mwge), or Uplizna (inebilizumab-cdon injection)? Yes ☐ No ☐

If aHUS:

Has the diagnosis of thrombocytopenic purpura (TTP) been ruled out (for example, patient has normal ADAMTS 13 activity)? Yes ☐ No ☐

(if no) Did your patient experience clinical improvement following a trial of plasma exchange? Yes ☐ No ☐

Has a Shiga toxin-producing E. coli (STEC) infection been ruled out? Yes ☐ No ☐

Is Soliris being prescribed by, or in consultation, with a hematologist and/or a nephrologist? Yes ☐ No ☐

If MG:

Does your patient have generalized myasthenia gravis (gMG)? Yes ☐ No ☐

Does your patient have non-ocular (no eye involvement) and persistent disease?

☐ Yes
☐ No, patient's disease involves the eye muscles OR patient's disease is NOT persistent
☐ Unknown

Did your patient test positive for AChR (anti-acetylcholine receptor antibody? Yes ☐ No ☐

Has your patient been treated for this diagnosis with any of the following drugs?

☐ azathioprine (Azasan, Imuran)
☐ cyclosporine (Sandimmune)
☐ mycophenolate mofetil (Cellcept)
☐ prednisone
☐ tacrolimus (Prograf)
☐ No or None of the above

Was your patient also treated for this diagnosis with a SECOND drug?

☐ azathioprine (Azasan, Imuran)
☐ cyclosporine (Sandimmune)
☐ mycophenolate mofetil (Cellcept)
☐ prednisone
☐ tacrolimus (Prograf)
☐ No or None of the above

(if no 2nd drug) Has your patient required chronic plasma exchange or intravenous immunoglobulin (IvIg)?

☐ Yes, plasma exchange
☐ Yes, IvIg
☐ Neither of the above

Did your patient fail the above treatments over 1 year or more as defined by ONE of the following:

1. Persistent symptoms of generalized myasthenia (for example, difficulty breathing or swallowing)
2. Reduced physical activity due to generalized symptoms of myasthenia (for example, double vision, talking, impairment of mobility)? Yes ☐ No ☐

Is the prescriber a neurologist OR is Soliris being prescribed in consultation with a neurologist? Yes ☐ No ☐

If NMOSD:

Was your patient's diagnosis confirmed by a positive blood serum test for anti-aquaporin-4 antibody? Yes ☐ No ☐

Has the patient tried and failed or had an inadequate response to Enspryng or Uplizna for neuromyelitis optica spectrum disorder? Yes ☐ No ☐

(if no) Is there documentation that the patient had failure or inadequate response [history of at least one relapse (acute attack from neuromyelitis spectrum disorder) in the last 12 months, or two relapses in the last 2 years] to ONE of the following systemic therapies:
A. azathioprine (Azasan, Imuran),
B. mycophenolate mofetil (Cellcept), or
C. rituximab (Rituxan, Ruxience, Truxima)? Yes ☐ No ☐

(if no) Does the patient have a contraindication per FDA label or significant intolerance to ALL of the following systemic therapies:
A. azathioprine (Azasan, Imuran),
B. mycophenolate mofetil (Cellcept), or
C. rituximab (Rituxan, Ruxience, Truxima)? Yes ☐ No ☐

Is the prescriber a neurologist OR is Soliris being prescribed in consultation with a neurologist? Yes ☐ No ☐

If PNH:

(if PNH) Did flow cytometry demonstrate either of the following?

- ☐ at least 10% PNH type III red cells
- ☐ greater than 50% of glycosylphosphatidylinositol-anchored proteins (GPI-AP)-deficient polymorphonuclear cells (PMNs)
- ☐ neither of the above

(if PNH) Has your patient had one of the following?

- ☐ at least one transfusion related to anemia secondary to PNH
- ☐ occurrence of a thromboembolic event (for example: DVT, PE)
- ☐ neither of the above

Is the prescriber a hematologist OR is Soliris being prescribed in consultation with a hematologist? Yes ☐ No ☐

Besides the drug being requested, other drugs in this class include: Empaveli (pegcetacoplan) and Ultomiris (ravulizumab-cwvz). Which of the following best describes your patient's situation?

☐ The patient is NOT taking Empaveli or Ultomiris at this time, nor will they in the future. The requested drug is the only one of these the patient is/will be using.
☐ The patient is currently on Empaveli or Ultomiris, but it will be stopped and the requested drug will be started.
☐ The patient is currently on Empaveli, and the requested drug will be added. The patient may continue to take BOTH drugs together.
☐ The patient is currently on Ultomiris, and the requested drug will be added. The patient may continue to take BOTH drugs together.
☐ The patient is currently on BOTH Empaveli AND the requested drug.
☐ The patient is currently on BOTH Ultomiris AND the requested drug.
☐ other/unknown

(if Empaveli or other) Will the patient take Soliris concurrently with Empaveli for MORE THAN 4 weeks?

- ☐ Yes or Unknown
- ☐ No

(if other/more than the requested drug) Please provide name

Additional pertinent information

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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