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 samples, please choose "new start of therapy". ☐ new start of therapy ☐ continuation of therapy:

(if continuation of therapy) What was the start date and the date of the last dose? Please include the dosages given.

(if continuation of therapy) Is there documentation that your patient had a positive clinical response to therapy with this medication (for example – with aHUS: reduced hemolysis, improved thrombocytopenia or renal function; 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, improvement in MG-ADL or QMG scores; NMOSD - reduction in relapse rate, reduction in symptoms (for example, pain, fatigue, motor function), or a slowing progression in symptoms)? Yes ☐ No ☐

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

With this current request, how is the medication being used?
☐ induction
☐ maintenance
☐ both induction and maintenance

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

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 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):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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?

☐ acute antibody mediated rejection
☐ chronic antibody-mediated rejection in recipients with persistently high B flow crossmatch after positive crossmatch kidney transplantation
☐ complement mediated hemolytic uremic syndrome (atypical hemolytic uremic syndrome, aHUS)
☐ geographic atrophy in age-related macular degeneration (AMD)
☐ myasthenia gravis (MG)
☐ neuromyelitis optica spectrum disorder (NMOSD, Devic disease or neuromyelitis optica [NMO])
☐ paroxysmal nocturnal hemoglobinuria (PNH)
☐ prevention of delayed graft function
☐ stem cell transplant-associated thrombotic microangiopathy
☐ systemic lupus erythematosus (SLE)
☐ typical hemolytic uremic syndrome (HUS)
☐ other (please specify):

Clinical Information

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

(if aHUS, NMOSD, or PNH) 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 this medication be used along with ANY of the following: a rituximab product (including Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima), a neonatal Fc receptor blocker (including Rystiggo, Vyvgart, Vyvgart Hytrulo), Enspryng (satralizumab-mwge subcutaneous injection), Fabhalta (iptacopan capsule), Ultomiris (ravulizumab-cwzy intravenous infusion or subcutaneous injection), Uplizna (inebilizumab-cdon intravenous infusion), or Zilbrysq (zilucoplan subcutaneous 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 the requested medication 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 ☐

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

Prior to starting therapy with Soliris, what is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification?
☐ Class I (pure ocular)
☐ Class II (mild generalized)
☐ Class III (moderate generalized)
☐ Class IV (severe generalized)
☐ Class V (intubation/myasthenic crisis)

Prior to starting therapy with Soliris, did the patient have a Myasthenia Gravis -Activities of Daily Living (MG-ADL) score of 6, or higher? Yes ☐ No ☐

The covered alternative is pyridostigmine. If the patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient

experienced. If the patient has NOT tried this drug, please provide details why the patient can't try this alternative.

Per the information provided above, which of the following is true for the patient in regards to the covered alternative?
☐ The patient is currently receiving pyridostigmine.
☐ The patient tried pyridostigmine, but it didn't work.
☐ The patient tried pyridostigmine, but they did not tolerate it.
☐ The patient cannot try pyridostigmine because of a contraindication to this drug.
☐ Other Please specify:

The covered alternatives are immunosuppressant therapies (for example, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus, cyclophosphamide, prednisone). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions the patient experienced.

Per the information provided above, which of the following is true for the patient in regards to the covered alternatives?
☐ The patient is currently receiving 2 of the alternatives for 1 year or more.
☐ The patient tried 2 of the alternatives, but none of these drugs worked.
☐ The patient tried 2 of the alternatives, but they did not tolerate any of them.
☐ The patient cannot try 2 of these alternatives because of a contraindication to each of these drugs.
☐ Other Please specify:

For each alternative that the patient didn't try, please provide details why they can't try that alternative [including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has].

Is the objective evidence of unresolved symptoms of generalized myasthenia gravis (gMG), such as difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility)? Yes ☐ No ☐

IIs this medication prescribed by, or 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) The covered alternative is rituximab (prior authorization may apply). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for the patient in regards to the covered alternative?
☐ The patient tried the alternative, but it didn't work
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other Please specify:

Is this medication prescribed by, or 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 OR flow cytometry was not done

(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
- ☐ neither of the above

Is this medication prescribed by, or in consultation with, a hematologist? Yes ☐ No ☐

Additional pertinent information: Please provide any additional pertinent clinical information, including: if the patient is currently on the requested medication (with dates of use) and how they have been receiving it (samples, out of pocket, etc.).

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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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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