

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SOLIRIS (eculizumab)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL
NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Documented diagnosis of paroxysmal nocturnal hemoglobinuria.
- Documented failure of or intolerance to other PNH treatments, including transfusion.
- Review by the DUR Board.

INFORMATION:

To be given in clinic setting only. Patients with HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code J1300, NDC number, and PA number.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

1 year with updated letter of medical necessity and documentation of patient progress.

9/20/10

<http://health.utah.gov/medicaid/pharmacy>