Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Eculizumab (Soliris), Pegcetacoplan (Empaveli), and Ravulizumab (Ultomiris)– Medical Necessity Request
****Complete page 1 for Initial Requests Only****

1. Does the member comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against encapsulated bacteria? **Yes or No**

2. Will the member not be on concomitant therapy with another inhibitor (such as Empaveli, Soliris, Ultomiris) to treat the same diagnosis unless otherwise recommended by drug label? **Yes or No**

3. Is the prescriber enrolled in the REMS program for the requested medication? **Yes or No**

4. What is the member's diagnosis?

□ **Paroxysmal nocturnal hemoglobinuria (PNH)**

1. Is the member's paroxysmal nocturnal hemoglobinuria confirmed by flow cytometry? **Yes or No**
   For Ultomiris requests: What is the member's weight? _____lbs or _____ kg

□ **Atypical hemolytic uremic syndrome (aHUS)**

1. Is the medication being used for the treatment of members with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS)? **Yes or No**
   For Soliris and Ultomiris requests: What is the member's weight? _____lbs or _____ kg

□ **Generalized myasthenia gravis (gMG)**

1. Is the member anti-acetylcholine receptor (AchR) antibody positive? **Yes or No**
   For Soliris and Ultomiris requests: What is the member's weight? _____lbs or _____ kg

□ **Neuromyelitis optica spectrum disorder (NMOSD)**

1. Is the member anti-aquaporin-4 (AQP4) antibody positive? **Yes or No**

□ Other:_____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Horizon NJ Health
Eculizumab (Soliris), Pegcetacoplan (Empaveli), and Ravulizumab (Ultomiris)– Medical Necessity Request
****Complete page 2 only for Subsequent/Renewal requests****

1. What is the member's diagnosis?

□ **Paroxysmal nocturnal hemoglobinuria (PNH)**

1. Has the member responded to treatment compared to baseline as defined by at least one of the following?
   - □ Decrease in serum lactate dehydrogenase (LDH) from pretreatment level
   - □ Increase in hemoglobin levels
   - □ Decrease in number of transfusions needed
   - □ Absence of unacceptable toxicity from the drug
   - □ None of the above

□ **Atypical hemolytic uremic syndrome (aHUS)**

1. Has the member responded to treatment compared to baseline as defined by at least one of the following?
   - □ Improvement in clinical signs and symptoms of thrombotic microangiopathy (mental status, seizures, angina, dyspnea, or thrombosis)
   - □ Decrease in serum lactate dehydrogenase (LDH) from pretreatment level
   - □ Reduction in serum creatinine or improvement in estimated glomerular filtration rate (eGFR)
   - □ Increase in platelet counts
   - □ Decrease in plasma exchange or infusion requirement
   - □ None of the above

□ **Generalized myasthenia gravis (gMG)**

1. Has the member responded to treatment compared to baseline as defined by at least one of the following?
   - □ Improvement in daily function, muscle weakness, or physical activities
   - □ Improvement in ocular, bulbar, respiratory, or limb function
   - □ None of the above

□ **Neuromyelitis optica spectrum disorder (NMOSD)**

1. Has the member responded to treatment compared to baseline as defined by at least one of the following?
   - □ Decrease in relapses
   - □ Decrease in hospitalizations
   - □ Decrease of corticosteroid use to treat acute relapses
   - □ Decrease of plasma exchange treatments
   - □ None of the above

□ Other:_____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**