JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Ultomiris

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Criteria Questions:

1. What is the diagnosis?
   - ❑ Paroxysmal nocturnal hemoglobinuria (PNH)
   - ❑ Atypical hemolytic uremic syndrome (aHUS)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's weight? _____ kg
4. Is this a request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section*
5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? ❑ Yes ❑ No
6. Has the patient experienced a positive response to therapy by any of the following? ***ACTION REQUIRED: If 'Yes', please attach chart notes or medical record documentation supporting positive clinical response.***
   - ❑ Yes, normalization of lactate dehydrogenase (LDH) levels, platelet counts
   - ❑ Yes, improvement in hemoglobin levels, normalization of lactate dehydrogenase (LDH) levels
   - ❑ None of the above
7. What is the prescribed maintance dose and frequency? _____ mg every _____ weeks
   No further questions

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Paroxysmal Nocturnal Hemoglobinuria (PNH)

8. Was the diagnosis of PNH confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs)? ❑ Yes ❑ No
9. How was the diagnosis established?
   - ❑ Quantification of PNH cells
   - ❑ Quantification of GPI-anchored protein deficient poly-morphonuclear cells, *skip to #11*
   - ❑ None of the above
10. What was the percentage of PNH cells? _____ %
    If percentage of PNH cells is greater than or equal to 5%, skip to #12.
11. What was the percentage of GPI-anchored protein deficient poly-morphonuclear cells? _____ %
12. Was flow cytometry used to demonstrate the deficiency of GPI-anchored proteins? ***ACTION REQUIRED: If Yes, attach flow cytometry report.*** ❑ Yes ❑ No
13. Is the patient switching from eculizumab to the requested drug? ❑ Yes ❑ No
14. Will the loading dose of the requested drug be administered 2 weeks after the last eculizumab infusion?
    ❑ Yes ❑ No
15. What is the prescribed loading dose? _____ mg
16. What is the prescribed maintenance dose and frequency beginning 2 weeks after the loading dose?
    _____ mg every _____ weeks

Section B: Atypical Hemolytic Uremic Syndrome (aHUS)

17. Is the disease caused by Shiga toxin? ❑ Yes ❑ No
18. Do tests confirm the absence of Shiga toxin? ❑ Yes ❑ No
19. What is the ADAMTS13 level? ***ACTION REQUIRED: Please attach documentation of ADAMTS13 level.***
    ❑ Yes ❑ No
20. Is the patient switching from eculizumab to the requested drug? ❑ Yes ❑ No

Send completed form to: Priority Partners Fax: 1-866-212-4756

21. Will the loading dose of the requested drug be administered 2 weeks after the last eculizumab infusion?
    ❑ Yes ❑ No

22. What is the prescribed loading dose? _____ mg

23. What is the prescribed maintenance dose and frequency beginning 2 weeks after the loading dose?
    _____ mg every _____ weeks

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756