P.O. Box 30192
Salt Lake City, UT 84120-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Soliris™
(eculizumab)

Therapeutic use: Treatment of paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis
Quantity Limit: 600 mg weekly for 4 weeks, followed by 900 mg 1 week later; then 900 mg every 2 weeks
Authorization Period: 6 months

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | | / | | | | |

ICD-9 | | | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | | - | | | | | Fax# | | | | - | | | | |

Physician's signature_____ Date signed | | | / | | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the patient being treated for paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis?	❑ Yes	❑ No
2.	Is the prescribing physician a hematologist?	❑ Yes	❑ No
3.	Diagnostic tests performed and affirmed: [check applicable box(s) and attach test results] ❑ Flow Cytometric Immunophenotyping (FCMI) ❑ PNH Gel Card Test (GAT) ❑ Ham Test ❑ Sucrose Lysis Test (SLT)	❑ Yes	❑ No
4.	Number of blood transfusions in previous year: _____		
5.	Current Hemoglobin _____ Date Tested_____		

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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