

**Blue Cross and Blue Shield of Vermont and The Vermont Health Plan
Prior Authorization Form
Soliris® (Eculizumab)**

BCBSVT and TVHP Fax # (888)-255-1006

If approval criteria are met, BCBSVT/TVHP will authorize coverage of Soliris® (Eculizumab). Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 BCBSVT/TVHP Member ID#: _____ Date of birth: _____
 Provider Name: _____ Provider Phone number: _____
 Provider Fax number: _____ PCP Name: _____

INDICATIONS FOR USE	YES	NO
1) Has patient been diagnosed with paroxysmal nocturnal hemoglobinuria (PNH) and need to reduce hemolysis?	<input type="checkbox"/>	<input type="checkbox"/>
2) Is patient 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has been given a meningococcal vaccine at least two weeks prior to initiation of therapy? If yes, Provide date _____	<input type="checkbox"/>	<input type="checkbox"/>
4) Will Prescription be dispensed at (circle one): Provider Office Restat Pharmacy		

BENEFIT APPROVAL

If criteria are met, eculizumab therapy initial approval for 3 months, renewable for a 6 month period. Dispensed in 30 days supply only

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.