

**Health New England  
Medication Request Form (MRF)  
Soliris® (eculizumab)**

**Please Fax to  
413-233-2777**

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| DO NOT WRITE IN BLOCKED AREAS<br>FOR INTERNAL USE ONLY |
| Contacted:   |
| Physician:   |
| Pharmacy:  |
| Patient:   |

|  |
|--|
| DO NOT WRITE IN BLOCKED AREAS<br>FOR INTERNAL USE ONLY |
| Approved:  |
| Denied:  |
| Returned:  |
| PA #   |

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Soliris®. Please complete this form and fax to Health New England at (413) 233-2777 and please allow 3-15 days to process. If you have any questions regarding this process, please contact Health New England Member Services Department at (800) 310-2835.

**J-Code: J3590**

**Medication Request Information (please complete each section of this form prior to transmittal):**

| Patient Information (all required) | Physician Information (all required)         |
|------------------------------------|--|
| <b>Patient Name:</b>               | <b>Physician Name :</b>                      |
|                                    | <b>Specialty:</b>                            |
|                                    | <b>NPI #:</b>                                |
| <b>Patient HNE ID#:</b>            | <b>HNE Provider #:</b>                       |
| <b>Patient Date of Birth:</b>      | <b>DEA #:</b>                                |
| <b>Allergies:</b>                  | <b>Area Code and Telephone #: ( ) -</b>      |
| <b>Diagnosis:</b>                  | <b>Area Code and Fax # (required): ( ) -</b> |

**Drug Information**

|  |                             |
|--|-----------------------------|
| <b>Requested Drug:</b> <input type="checkbox"/> Soliris  |                             |
| <b>Dose (please be specific):</b>  | <b>Length of Treatment:</b> |
| <b>Weight (required)</b>   |                             |
| <b>Indication:</b>   |                             |
| <input type="checkbox"/> Paroxysmal nocturnal hemoglobinuria<br><input type="checkbox"/> Other (please describe) |                             |

**Documentation of Medical Necessity (check all that apply): In addition, a letter of medical necessity must be attached.**

- Prescribing physician is a hematologist
- Member has been vaccinated for meningococcal infection. Date: \_\_\_\_\_
- Diagnosis has been confirmed by flow cytometry (results must be attached)
- PNH type III erythrocytes are \_\_\_\_\_%
- Platelet count is \_\_\_\_\_
- Lactate dehydrogenase level is \_\_\_\_\_ times the normal range
- Number of transfusions the patient has had in the past 12 months is \_\_\_\_\_.
- Patient does not have a systemic infection
- Member is over the age of 18 years old
- Other pertinent history: \_\_\_\_\_