

Health New England Medication Request Form (MRF)

Soliris® (eculizumab)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Please Fax to
413-233-2777

DO NOT WRITE IN BLOCKED AREAS 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)
Patient Name:	Physician Name :
	Specialty:
	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Area Code and Telephone #: () -
Diagnosis:	Area Code and Fax # (required): () -

Drug Information

Requested Drug: <input type="checkbox"/> Soliris	
Dose (please be specific):	Length of Treatment:
Weight (required)	
Indication:	
<input type="checkbox"/> Paroxysmal nocturnal hemoglobinuria <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: _____