

**Request for Prior Authorization for C5b Complement inhibitors**  
**Website Form – [www.highmarkhealthoptions.com](http://www.highmarkhealthoptions.com)**  
**Submit request via: Fax - 1-855-476-4158**

All requests for C5b Complement inhibitors require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

C5b Complement inhibitors Prior Authorization Criteria:

For all requests for C5b Complement inhibitors all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Coverage may be provided with a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) and the following criteria are met:

- Medication is prescribed by, or in consultation with, a hematologist, oncologist, immunologist, or genetic specialist
- Member has a diagnosis of PNH confirmed by flow cytometry testing. Flow Cytometry pathology report must be supplied and demonstrate at least 2 different GPI protein deficiencies within 2 different cell lines from granulocytes, monocytes, or erythrocytes.
- Member is transfusion dependent as defined by having a transfusion within the last 12 months and one of the following:
  - Member's hemoglobin is less than or equal to 7 g/dL
  - Member has symptoms of anemia and the hemoglobin is less than or equal to 9 g/dL (**Soliris only**)
  - Member has symptoms of anemia and the hemoglobin is less than or equal to 10 g/dL (**Ultomiris only**)
- Must have a Lactate dehydrogenase (LDH) level at least 1.5 times the upper limit of the normal range (laboratory results with reference range must be submitted)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
  - Documentation of each of the following:
    - Documentation of a recent (within 3 months) LDH level that shows a reduction from baseline
    - Documentation that hemoglobin has not dropped by more than 2 g/dL from baseline.
      - If baseline hemoglobin was less than 9g/dL, then the most recent hemoglobin must remain above 7g/dL
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of atypical hemolytic uremic syndrome (aHUS) and the following criteria are met:

- The member weighs at least 5 kilograms
- Medication is prescribed by, or in consultation with, a hematologist, oncologist, immunologist, genetic specialist, or nephrologist
- Must provide documentation of hemolysis such as an elevation in serum LDH and serum creatinine above the upper limits of normal or required dialysis.
- The diagnosis of aHUS is supported by the absence of Shiga toxin-producing *E.coli* infection
- Must provide documentation member does not have a disintegrin and metalloproteinase with thrombospondin type 1 motif member 13 (ADAMTS13) deficiency
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Documentation from the provider that the member had a positive clinical response as evidenced by any of the following:
    - An increase in platelet count from baseline
    - Maintenance of normal platelet counts and LDH levels for at least four weeks
    - A 25% reduction in serum creatinine for a minimum of four weeks
    - Documentation within the last 12 weeks that the member has **NOT** experienced any of the following:
      - A decrease in platelet count of >25% from baseline
      - Plasma exchange or plasma infusion
      - New dialysis requirement
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of generalized Myasthenia Gravis (gMG) (**Soliris (eculizumab) ONLY**) and the following criteria are met:

- Medication is prescribed by, or in consultation with a neurologist
- Documentation of a positive serologic test for anti-acetylcholine antibodies
- Documentation the member meets the Myasthenia Gravis Foundation of America Clinical Classification II to IV generalized myasthenia gravis
- Documentation the member has a Myasthenia Gravis-Specific Activities of Daily Living (MG-ADL) total score  $\geq 6$
- Documentation of at least one of the following:
  - Failed treatment over 1 year or more with 2 or more immunosuppressive therapies either in combination or as monotherapy (e.g. azathioprine, cyclophosphamide, methotrexate)
  - Failed treatment over 1 year or more with at least 1 immunosuppressive therapy while on chronic plasmapheresis or plasma exchange (PE)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - First reauthorization criteria (member on therapy for 0 to 6 months)
    - Documentation from the provider that the member had a positive clinical response and tolerates Soliris therapy supported by at least one of the following:

- A 3 point improvement in the member's total MG-ADL score
- A 5 point improvement in QMG total score
- Subsequent reauthorization criteria (member on therapy  $\geq$  6 months)
  - Documentation from the prescriber indicating stabilization or improvement in condition.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of Neuromyelitis Optica Spectrum Disorder (NMOSD) (**Soliris (eculizumab) ONLY**) and the following criteria are met:

- Documentation of a positive test for AQP4-IgG antibodies
- Documentation of at least 2 relapses in the last 12 months or 3 relapses in the last 24 months with at least 1 relapse in the last 12 months
- Documentation of an Expanded Disability Status Scale (EDSS) score of  $\leq$  7
- If using concurrent corticosteroids, dose is less than or equal to the equivalent of prednisone 20 mg per day
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - Documentation from the prescriber indicating stabilization or improvement in condition.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

#### References:

1. Soliris (eculizumab) [package insert]. Cheshire, CT: Alexion Pharm; July 2018.
2. Niaudet, P. Complement-mediated Hemolytic Uremic Syndrome. UpToDate. Updated October 2018.
3. Brodsky, RA. Clinical Manifestations and Diagnosis of Paroxysmal Nocturnal Hemoglobinuria. UpToDate. Updated November 2017.
4. Brodsky, RA. Treatment and Prognosis of Paroxysmal Nocturnal Hemoglobinuria. UpToDate. Updated January 2019.
5. Soliris® (eculizumab) Clinical Pharmacology. Accessed 1/2019.
6. Noris M, Bresin E, Mele C, et al. Genetic Atypical Hemolytic-Uremic Syndrome. 2007 Nov 16 [Updated 2016 Jun 9]. In: Pagon RA, Adam MP, Ardinger HH, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2017. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK1367/>
7. Managing the risk of meningococcal disease among patients who receive eculizumab therapy. Centers for Disease Control and Prevention. Updated July 2017. Accessed January 2019. Available from: <https://www.cdc.gov/meningococcal/clinical/eculizumab.html>

8. Sanders D, Wolfe G, Benatar M, et al. International Consensus Guidance for Management of Myasthenia Gravis. 2016 American Academy of Neurology. Accessed 1/2019. Available from: <http://n.neurology.org/content/neurology/early/2016/06/29/WNL.0000000000002790.full.pdf>.
9. Sahin F, Olga MA, Ayer M, et al. Pseg PNH diagnosis, follow-up and treatment guidelines. *Am J Blood Res.* 2016 Aug;6(2):19-27.
10. Hillmen P, Young NS, Schubert J, et al. The complement inhibitor eculizumab in paroxysmal nocturnal hemoglobinuria. *N Engl J Med.* 2006 Sep;355(12):1233-43.
11. Ultomiris [package insert]. Boston, MA: Alexion Pharmaceuticals, Inc.; 12/2018
12. Borowitz MJ, Craig FE, et al. Guidelines for the diagnosis and monitoring of paroxysmal nocturnal hemoglobinuria and related disorders by flow cytometry. *Cytometry B Clin Cytom.* 2010;78(4):211.
13. Pittock, S. J., Berthele, A., Fujihara, K., Kim, H. J., Levy, M., Palace, J., ... Wingerchuk, D. M. (2019). Eculizumab in Aquaporin-4–Positive Neuromyelitis Optica Spectrum Disorder. *New England Journal of Medicine.* doi: 10.1056/nejmoa1900866

**Attachment 1.** MG Activities of Daily Living (MG-ADL) profile

Grade	0	1	2	3	Score
Talking	Normal	Intermittent slurring or nasal speech	Constant slurring or nasal, but can be understood	Difficult to understand speech	
Chewing	Normal	Fatigue with solid food	Fatigue with soft food	Gastric tube	
Swallowing	Normal	Rare episode of choking	Frequent choking necessitating changes in diet	Gastric tube	
Breathing	Normal	Shortness of breath with exertion	Shortness of breath at rest	Ventilator dependence	
Impairment of ability to brush teeth or comb hair	None	Extra effort, but no rest periods needed	Rest periods needed	Cannot do one of these functions	
Impairment of ability to arise from a chair	None	Mild, sometimes uses arms	Moderate, always uses arms	Severe, requires assistance	
Double vision	None	Occurs, but not daily	Daily, but not constant	Constant	
Eyelid droop	None	Occurs, but not daily	Daily, but not constant	Constant	
					Total score _____

**Attachment 2. Quantitative Myasthenia gravis scale**

Test Items Weakness	None	Mild	Moderate	Severe
Double vision on lateral gaze <b>right</b> or <b>left</b> (circle one)	61	11–60	1–10	spontaneous
Ptosis (upward gaze)	61	11–60	1–10	spontaneous
Facial muscles	normal lid	complete, weak, some resistance	complete, without resistance	incomplete
Swallowing 4 oz. water (½ cup)	normal	Minimal coughing or throat clearing	severe coughing/ choking or nasal regurgitation	cannot swallow (test not attempted)
Speech following counting aloud from 1 to 50 (onset of dysarthria)	none at #50	dysarthria at #30–49	dysarthria at #10–29	dysarthria at #9
Right arm outstretched (90° sitting)	240	90–239	10–89	0–9
Left arm outstretched (90° sitting)	240	90–239	10–89	0–9
Vital capacity (% predicted)	≥80%	65–79%	50–64%	<50%
Right hand grip (kg)				
male	≥45	15–44	5–14	0–4
female	≥30	10–29	5–9	0–4
Left hand grip (kg)				
male	≥35	15–34	5–14	0–4
female	≥25	10–24	5–9	0–4
Head lifted (45° supine)	120	30–119	1–29	0
Right leg outstretched (45° supine)	100	31–99	1–30	0
Left leg outstretched (45° supine)	100	31–99	1–30	0

\*Total QMG score range 0–39.



**Attachment 3. Myasthenia Gravis Foundation of America Clinical Classification**

Class	Clinical symptoms
I	Any ocular weakness
II	Mild Weakness. May also have ocular muscle weakness of any severity
II A	Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal, respiratory muscles or both
II B	Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles or both
III	Moderate weakness affecting other than ocular muscles. May also have ocular muscle weakness of any severity
III A	Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal, respiratory muscles or both
III B	Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles or both
IV	Severe weakness affecting other than ocular muscles. May also have ocular muscle weakness of any severity
IV A	Predominantly affecting limb, axial muscles, or both. May also have lesser involvement of oropharyngeal, respiratory muscles or both
IV B	Predominantly affecting oropharyngeal, respiratory muscles, or both. May also have lesser or equal involvement of limb, axial muscles or both
V	Defined by intubation, with or without mechanical ventilation, except when employed during routine postoperative management

**Attachment 4.** Expanded Disability Status Scale (EDSS)

Score	Description
1.0	No disability, minimal signs in one functional system (FS)
1.5	No disability, minimal signs in more than one FS
2.0	Minimal disability in one FS
2.5	Mild disability in one FS or minimal disability in two FS
3.0	Moderate disability in one FS, or mild disability in three or four FS. No impairment to walking
3.5	Moderate disability in one FS and more than minimal disability in several others. No impairment to walking
4.0	Significant disability but self-sufficient and up and about some 12 hours a day. Able to walk without aid or rest for 500m
4.5	Significant disability but up and about much of the day, able to work a full day, may otherwise have some limitation of full activity or require minimal assistance. Able to walk without aid or rest for 300m
5.0	Disability severe enough to impair full daily activities and ability to work a full day without special provisions. Able to walk without aid or rest for 200m
5.5	Disability severe enough to preclude full daily activities. Able to walk without aid or rest for 100m
6.0	Requires a walking aid – cane, crutch, etc. – to walk about 100m with or without resting
6.5	Requires two walking aids – pair of canes, crutches, etc. – to walk about 20m without resting
7.0	Unable to walk beyond approximately 5m even with aid. Essentially restricted to wheelchair; though wheels self in standard wheelchair and transfers alone. Up and about in wheelchair some 12 hours a day
7.5	Unable to take more than a few steps. Restricted to wheelchair and may need aid in transferring. Can wheel self but cannot carry on in standard wheelchair for a full day and may require a motorised wheelchair
8.0	Essentially restricted to bed or chair or pushed in wheelchair. May be out of bed itself much of the day. Retains many self-care functions. Generally has effective use of arms
8.5	Essentially restricted to bed much of day. Has some effective use of arms retains some self-care functions
9.0	Confined to bed. Can still communicate and eat
9.5	Confined to bed and totally dependent. Unable to communicate effectively or eat/swallow
10.0	Death due to MS

**C5B COMPLEMENT INHIBITORS (SOLIRIS AND ULTOMIRIS)  
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158  
If needed, you may call to speak to a Pharmacy Services Representative.  
**PHONE:** (844) 325-6253 Monday through Friday 8:30am to 5:00pm

**PROVIDER INFORMATION**

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

**MEMBER INFORMATION**

Member Name:	DOB:
Health Options ID:	Member weight: _____ pounds or _____ kg

**REQUESTED DRUG INFORMATION**

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Billing Information**

This medication will be billed:  at a pharmacy **OR**  
 medically (if medically please provide a JCODE: \_\_\_\_\_)

Place of Service:  Hospital  Provider's office  Member's home  Other

**Place of Service Information**

Name:	NPI:
Address:	Phone:

**REFERENCE VALUES**

Lab	Initial (Pre-Treatment) Value	Reference Range	Date	Post-Therapy Value (Reauthorization only)	Reference Range	Date
Hemoglobin (Hgb)						
Lactate dehydrogenase (LDH)						
Platelet count						
Serum Creatinine						
Myasthenia Gravis-Specific Activities of Daily Living (MG-ADL) total score		N/A			N/A	
Quantitative Myasthenia Gravis (QMG) total score		N/A			N/A	



**C5B COMPLEMENT INHIBITORS (SOLIRIS AND ULTOMIRIS)  
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158  
If needed, you may call to speak to a Pharmacy Services Representative.  
**PHONE:** (844) 325-6253 Monday through Friday 8:30am to 5:00pm

**MEMBER INFORMATION**

Member Name:	DOB:
Health Options ID:	Member weight: _____ pounds or _____ kg

**MEDICAL HISTORY (Complete for ALL requests)**

**Diagnosis:** \_\_\_\_\_

**For Paroxysmal Nocturnal Hemoglobinuria (PNH) only:**

Does the member's flow cytometry pathology report demonstrate at least 2 different GPI protein deficiencies within 2 different cell lines from granulocytes, monocytes, or erythrocytes? Please include a copy  Yes  No

Has the patient had a blood transfusion within the last 12 months?  Yes  No

Does the patient have symptoms of anemia?  Yes  No

**For Atypical Hemolytic Uremic Syndrome only:**

Has the absence of Shiga toxin-producing *E.coli* been confirmed?  Yes  No

Does the member have an ADAMTS13 deficiency?  Yes  No Is the member currently on dialysis?  Yes  No

**For generalized Myasthenia Gravis only:**

Does the patient have anti-acetylcholine antibodies?  Yes  No

What is the member's Myasthenia Gravis Foundation of America Clinical Classification? \_\_\_\_\_

**For Neuromyelitis Optica Spectrum Disorder:**

Is documentation of a positive test for AQP4-IgG antibodies provided?  Yes  No

What is the member's Expanded Disability Status Scale (EDSS) score? \_\_\_\_\_

Has the member had at least 2 relapses in the last 12 months or 3 relapses in the last 24 months with at least 1 relapse in the last 12 months?  Yes  No

**CURRENT or PREVIOUS THERAPY**

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why / Current)

**REAUTHORIZATION**

Has the member experienced a significant improvement with treatment?  Yes  No If Yes, please include documentation

**For Paroxysmal Nocturnal Hemoglobinuria (PNH) only:**

Has the patient had a blood transfusion since taking Soliris?  Yes  No

**For Atypical Hemolytic Uremic Syndrome only:**

Has the patient been able to maintain a normal platelet or LDH level for at least four weeks?  Yes  No

Has the patient experienced a 25% serum creatinine reduction for at least four weeks?  Yes  No

In the past 12 weeks, has the patient had any of the following?

A decrease in platelet count of >25% from baseline  Yes  No

Increased need for plasma exchange or plasma infusion  Yes  No

New dialysis requirement  Yes  No

**SUPPORTING INFORMATION or CLINICAL RATIONALE**

**Prescribing Provider Signature**

**Date**

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Updated: 11/2019  
DMMA Approved: 11/2019