



Eculizumab (Soliris®) Injectable Medication Precertification Request

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: Start of treatment Continuation of therapy, date of last treatment _____ **Today's date:** _____

Date needed: _____

Ship to: Doctor's office Patient Other: _____ **Phone:** _____

Dispensing Provider: Aetna Specialty Pharmacy® or Other: _____
Phone: _____ Fax: _____ **TIN:** _____ **PIN:** _____

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Circle one): M.D. D.O. N.P. P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St. Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____					

D. DIAGNOSIS INFORMATION

Primary ICD-9: _____

Secondary ICD-9: _____ Other ICD-9 Code: _____

E. CLINICAL INFORMATION

Yes No Does the patient have a documented diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)?

Yes No Is the patient transfusion dependent (at least 1 transfusion in the previous 24 months due to documented hemoglobin less than 7g/dL in persons without anemic symptoms or less than 9g/dL in persons with symptoms from anemia)?

Yes No Does the patient have a documented history of major adverse vascular events from thromboembolism?

Yes No Has the patient been vaccinated against meningococcal infection (at least 2 weeks prior to initiation of therapy, if not previously vaccinated)?

If No:

Yes No Will the patient be vaccinated at least 2 weeks prior to initiation of therapy?
Anticipated date of vaccination: _____

Yes No Does the patient have a documented diagnosis of atypical hemolytic uremic syndrome without serious unresolved Neisseria meningitidis infection?

F. PRESCRIPTION INFORMATION – To be completed only if Aetna Specialty Pharmacy is Dispensing Provider

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Soliris® CPB # 0807	10mg/ml; 30ml single dose vial			

*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.
*If the prescriber is providing the drug, the provider must verify benefits.

Prescriber's Signature: _____ **Date:** ____ / ____ / ____
(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)

Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space: _____