together with CCHP™

Prior Authorization Form: **Soliris**

If this is an urgent request, please call Together with CCHP Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Incomplete responses may delay this request.			
Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone #:		Provider Fax #:	Provider NPI #:
Patient Name:	Together with CCHP Member ID #:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Quantity Dispensed (including units):

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

New medication **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	**Yes** ☐ **No** ☐
Diagnosis:		**Date of diagnosis:**	

Please indicate place of administration:
Physician's Office **Hospital/Facility** **Patient Home** **Other**

Please provide hospital/facility information:
Name: _____
Phone #: _____
Address: _____
_____

Will the drug be: (select one)
Billed directly by the provider via JCODE
JCODE: _____
Billed by a pharmacy and delivered to the provider ☐
Billed by a pharmacy and delivered to the patient ☐

Medical History

Was a meningococcal vaccine administered? ☐ Yes ☐ No
If yes, please provide the date vaccine was administered: _____

Please provide anticipated date of first dose of Soliris: _____

Diagnosis:

Paroxysmal Nocturnal Hemoglobinuria (PNH):

Please provide documentation of Flow Cytometry pathology report which confirms diagnosis

Please provide laboratory report of lactate dehydrogenase level (LDH), including reference range

Atypical Hemolytic Uremic Syndrome (aHUS)

Please provide any additional clinical information which should be considered in the space below: