# Ultomiris® (ravulizumab-cwvz) Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**Aetna Precertification Notification**
**Phone:** 1-866-752-7021
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**
**Phone:** 1-866-503-0857
**FAX:** 1-844-268-7263

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

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

## A. PATIENT INFORMATION

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

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

**Medicare:** ☐ Yes ☐ No If yes, provide ID #:

**Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: | | | *(Check 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):* ☐ **Hematologist** ☐ **Other**: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

## E. PRODUCT INFORMATION

**Request is for Ultomiris (ravulizumab-cwvz):**

**Loading Dose:** _____ **Frequency:** _____

**Maintenance Dose:** _____ **Frequency:** _____

## F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

**Primary ICD Code:** ☐ _____ **Secondary ICD Code :** _____ **Other ICD Code:** _____

## G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

**For All Requests (clinical documentation required):**

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition:
☐ Cardiopulmonary: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

***Continued on next page***

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION (*continued*)** – Required clinical information must be completed in its entirety for all precertification requests.

**For Initiation Requests (clinical documentation required):**

☐ Yes ☐ No Is the patient switching from eculizumab to the requested drug?
→ ☐ Yes ☐ No Will the loading dose of the requested drug be administered 2 weeks after the last eculizumab infusion?

**Paroxysmal nocturnal hemoglobinuria (PNH)**

☐ Yes ☐ No Has the diagnosis been confirmed by flow cytometry results?
☐ Yes ☐ No Does the patient have a deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins?
How was the diagnosis established? ☐ Quantification of PNH cells
→ What was the percentage of PNH cells? ☐ Less than 5% ☐ Greater than or equal to 5%
☐ Quantification of GPI-anchored protein deficient poly-morphonuclear cells
What was the percentage of GPI-anchored protein deficient poly-morphonuclear cells?
→ ☐ Less than 51% ☐ Greater than or equal to 51%
☐ None of the above

**Atypical hemolytic uremic syndrome**

☐ Yes ☐ No Is the disease caused by Shiga toxin?
→ ☐ Yes ☐ No Do tests confirm the absence of Shiga toxin?
What is the ADAMTS13 level? ☐ Less than or equal to 5% ☐ Greater than 5%

**For All Continuation Requests (clinical documentation required):**

☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
☐ Yes ☐ No Has the patient demonstrated a positive response to therapy (e.g., normalization of lactate dehydrogenase (LDH) levels, platelet counts or improvement in hemoglobin levels)?

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.