

Sample Letter of Medical Necessity for SOLIRIS® (eculizumab) in Atypical Hemolytic Uremic Syndrome (atypical-HUS) to Inhibit Complement-Mediated Thrombotic Microangiopathy (TMA)

INDICATION & SELECT IMPORTANT SAFETY INFORMATION FOR SOLIRIS® (eculizumab) INDICATION

SOLIRIS is indicated for the treatment of patients with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy.

Limitation of Use

SOLIRIS is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

SELECT IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS MENINGOCOCCAL INFECTIONS

SOLIRIS, a complement inhibitor, increases the risk of serious infections caused by *Neisseria meningitidis* [see *Warnings and Precautions (5.1)*]. Life-threatening and fatal meningococcal infections have occurred in patients treated with complement inhibitors. These infections may become rapidly life-threatening or fatal if not recognized and treated early.

- Complete or update vaccination for meningococcal bacteria (for serogroups A, C, W, Y, and B) at least 2 weeks prior to the first dose of SOLIRIS, unless the risks of delaying SOLIRIS therapy outweigh the risk of developing a serious infection. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against meningococcal bacteria in patients receiving a complement inhibitor. See *Warnings and Precautions (5.1)* for additional guidance on the management of the risk of serious infections caused by meningococcal bacteria.
- Patients receiving SOLIRIS are at increased risk for invasive disease caused by *Neisseria meningitidis*, even if they develop antibodies following vaccination. Monitor patients for early signs and symptoms of serious meningococcal infections and evaluate immediately if infection is suspected.

Because of the risk of serious meningococcal infections, SOLIRIS is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called ULTOMIRIS and SOLIRIS REMS [see *Warnings and Precautions (5.2)*].

Please see Important Safety Information on pages [1](#) and [5-6](#) and full [Prescribing Information](#) for SOLIRIS, including Boxed WARNING regarding serious and life-threatening or fatal meningococcal infections.


SOLIRIS®
(eculizumab)
Injection for Intravenous Use
300 mg/30 mL vial

Introduction

Payers may request a letter of medical necessity to support coverage of SOLIRIS. The letter should explain why the drug is medically necessary for the specific patient and may include supporting documentation (eg, medical records, peer-reviewed literature, Prescribing Information, clinical treatment history, etc). The letter may be submitted as part of a prior authorization (PA) request, with the claim form, or in response to a payer's request for additional documentation. The letter should include patient-specific information, be on the prescriber's letterhead, be signed by the prescriber, and be submitted to a payer to support a PA request or claim for SOLIRIS.

This sample letter of medical necessity is provided for informational purposes only and is not based on legal advice or official guidance from payers. It is not intended to increase or maximize reimbursement by any payer. Alexion does not warrant, promise, guarantee, or make any statement that the use of this information will result in coverage or payment for SOLIRIS or that any payment received will cover providers' costs.

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Please see Important Safety Information on pages [1](#) and [5-6](#) and full [Prescribing Information](#) for SOLIRIS, including **Boxed WARNING** regarding serious and life-threatening or fatal meningococcal infections.

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[John Doe, MD]
[Address]
[City, State, ZIP Code]
[(888) 555-5555]

SAMPLE ONLY
Please copy onto your letterhead.

[Date]
[Contact Name] [Title]
[Name of Health Insurance Company]
[Address] [City, State Zip Code]
Insured: [Name]; Policy Number: [Number]; Group Number: [Number]
Date(s) of service: [Date(s)]

Dear [Contact Name]:

I am writing on behalf of my patient, [First Name] [Last Name], to request that [name of health insurance company] approve coverage and appropriate reimbursement associated with [Mr/Ms/Mrs/other title] [Last Name]'s treatment with SOLIRIS® (eculizumab). SOLIRIS is indicated for the treatment of patients with atypical hemolytic uremic syndrome (atypical-HUS) to inhibit complement-mediated thrombotic microangiopathy (TMA). Limitation of Use: SOLIRIS is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

1 Patient History and Diagnosis (reference page 2 for examples):

[Name of patient] is a[n] [age]-year-old [male/female] born [MM-DD-YEAR] who requires treatment with SOLIRIS after being diagnosed with atypical-HUS on [date of diagnosis MM-DD-YEAR].

[Provide a brief description of the patient's atypical-HUS symptoms and historical management, including any patient-specific clinical scenarios.]

If policy requires step therapy (optional)

Your policy requires a step edit through [eculizumab-aagh or eculizumab-aeeb]. In my medical opinion, [eculizumab-aagh or eculizumab-aeeb] is not an appropriate step for my patient based on the following relevant criteria [insert reason(s) why eculizumab-aagh or eculizumab-aeeb may not be appropriate for your patient. Refer to the list of potential considerations from the Sample Appeal Letter for SOLIRIS on pages 6 and 7].

In my medical opinion, SOLIRIS is the most appropriate treatment for [name of patient]'s atypical-HUS based on the clinical efficacy and safety data.

Dosing

For patients 18 years of age and older with atypical-HUS, the recommended dosing regimen for SOLIRIS consists of 900 mg weekly for the first 4 weeks, followed by 1200 mg for the fifth dose 1 week later, and then 1200 mg every 2 weeks thereafter.¹

For patients less than 18 years of age with atypical-HUS, the recommended dosing regimen for SOLIRIS is based on body weight according to the following schedule:

Patient Body Weight	Induction	Maintenance
40 kg and over	900 mg weekly x 4 doses	1200 mg at week 5; then 1200 mg every 2 weeks
30 kg to less than 40 kg	600 mg weekly x 2 doses	900 mg at week 3; then 900 mg every 2 weeks
20 kg to less than 30 kg	600 mg weekly x 2 doses	600 mg at week 3; then 600 mg every 2 weeks
10 kg to less than 20 kg	600 mg weekly x 1 dose	300 mg at week 2; then 300 mg every 2 weeks
5 kg to less than 10 kg	300 mg weekly x 1 dose	300 mg at week 2; then 300 mg every 3 weeks

Based on the above facts, I am confident you will agree that SOLIRIS is indicated and medically necessary for the treatment of atypical-HUS in this patient. If you have any further questions, please feel free to call me at [prescriber's telephone number] to discuss. Thank you in advance for your immediate attention to this request.

Sincerely,

[Prescriber's name], [Credentials]
[Prescriber's practice name] [Phone number]

Enclosures [Paper copy of original claim form, supporting clinical documentation, Prescribing Information, FDA approval letter for SOLIRIS in atypical-HUS, invoice, etc]

Please copy language above the line for sample letter.

Please see Important Safety Information on pages **1** and **5-6** and full **Prescribing Information** for SOLIRIS, including **Boxed WARNING** regarding serious and life-threatening or fatal meningococcal infections.

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1 Medical History (Including Clinical Signs, Symptoms, and Laboratory Results)

Patient's medical history:

- Clinical notes/laboratory reports with evidence of microangiopathic hemolytic anemia, acute kidney injury, and thrombocytopenia
- Platelet counts (note, only $<150 \times 10^9/L$ or $>25\%$ decrease from baseline)¹
- Evidence of hemolysis, including elevated lactate dehydrogenase (LDH) levels
- Elevated serum creatinine levels and impaired renal function as measured by eGFR
- Dialysis history, if any
- History of prior interventions with plasma exchange, plasma infusion, and/or dialysis
- ADAMTS13 activity level results (note, only $>5\%$)¹ to rule out thrombotic thrombocytopenic purpura (TTP)
- Negative test result for STEC-HUS
- Contraindications, if any, to any agents used in the treatment of atypical-HUS
- Meningococcal vaccinations: Provide documentation of initial series and/or most recent boosters for meningococcal vaccinations at least 2 weeks prior to the first proposed treatment with SOLIRIS (eculizumab)
- If urgent SOLIRIS (eculizumab) therapy is indicated in an unvaccinated patient, administer meningococcal vaccine(s) as soon as possible and provide patients with antibacterial drug prophylaxis²
- Genetic test results, if available, and supportive of diagnosis. Please note, genetic testing is not required for diagnosis of atypical-HUS

For additional access resources, please visit:



Explore Alexion
Access Navigator

ALEXION ACCESS NAVIGATOR

Alexion Access Navigator is a dedicated resource website for US Healthcare Professionals and their offices that contains downloadable access and reimbursement materials for SOLIRIS® (eculizumab).

Online: <https://alexionaccessnavigator.com>

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SELECT IMPORTANT SAFETY INFORMATION FOR SOLIRIS® (eculizumab) (cont'd)

CONTRAINDICATIONS

- SOLIRIS is contraindicated for initiation in patients with unresolved serious *Neisseria meningitidis* infection.

WARNINGS AND PRECAUTIONS

Serious Meningococcal Infections

SOLIRIS, a complement inhibitor, increases a patient's susceptibility to serious, life-threatening, or fatal infections caused by meningococcal bacteria (septicemia and/or meningitis) in any serogroup, including non-groupable strains. Life-threatening and fatal meningococcal infections have occurred in both vaccinated and unvaccinated patients treated with complement inhibitors.

Revaccinate patients in accordance with ACIP recommendations considering the duration of therapy with SOLIRIS. Note that ACIP recommends an administration schedule in patients receiving complement inhibitors that differs from the administration schedule in the vaccine prescribing information.

If urgent SOLIRIS therapy is indicated in a patient who is not up to date with meningococcal vaccines according to ACIP recommendations, provide the patient with antibacterial drug prophylaxis and administer meningococcal vaccines as soon as possible. Various durations and regimens of antibacterial drug prophylaxis have been considered, but the optimal durations and drug regimens for prophylaxis and their efficacy have not been studied in unvaccinated or vaccinated patients receiving complement inhibitors, including SOLIRIS. The benefits and risks of treatment with SOLIRIS, as well as those associated with antibacterial drug prophylaxis in unvaccinated or vaccinated patients, must be considered against the known risks for serious infections caused by *Neisseria meningitidis*.

Vaccination does not eliminate the risk of serious meningococcal infections, despite development of antibodies following vaccination.

Closely monitor patients for early signs and symptoms of meningococcal infection and evaluate patients immediately if infection is suspected. Inform patients of these signs and symptoms and instruct patients to seek immediate medical care if these signs and symptoms occur. Promptly treat known infections. Meningococcal infection may become rapidly life-threatening or fatal if not recognized and treated early. Consider interruption of SOLIRIS in patients who are undergoing treatment for serious meningococcal infection, depending on the risks of interrupting treatment in the disease being treated.

ULTOMIRIS and SOLIRIS REMS

Due to the risk of serious meningococcal infections, SOLIRIS is available only through a restricted program called ULTOMIRIS and SOLIRIS REMS.

Prescribers must enroll in the REMS, counsel patients about the risk of serious meningococcal infection, provide patients with REMS educational materials, assess patient vaccination status for meningococcal vaccines (against serogroups A, C, W, Y, and B) and vaccinate if needed according to current ACIP recommendations two weeks prior to the first dose of SOLIRIS. Antibacterial drug prophylaxis must be prescribed if treatment must be started urgently and the patient is not up to date with both meningococcal vaccines according to current ACIP recommendations at least two weeks prior to the first dose of SOLIRIS. Patients must receive counseling about the need to receive meningococcal vaccines and to take antibiotics as directed, the signs and symptoms of meningococcal infection, and be instructed to carry the Patient Safety Card with them at all times during and for 3 months following SOLIRIS treatment.

Further information is available at www.UltSolREMS.com or 1-888-765-4747.

Other Infections

Serious infections with *Neisseria* species (other than *Neisseria meningitidis*), including disseminated gonococcal infections, have been reported.

SOLIRIS blocks terminal complement activation; therefore, patients may have increased susceptibility to infections, especially with encapsulated bacteria, such as infections with *Neisseria meningitidis* but also *Streptococcus pneumoniae*, *Haemophilus influenzae*, and to a lesser extent, *Neisseria gonorrhoeae*. Additionally, *Aspergillus* infections have occurred in immunocompromised and neutropenic patients. Children treated with SOLIRIS may be at increased risk of developing serious infections due to *Streptococcus pneumoniae* and *Haemophilus influenzae* type b (Hib). Administer vaccinations for the prevention of *Streptococcus pneumoniae* and *Haemophilus influenzae* type b (Hib) infections according to ACIP recommendations. Patients receiving SOLIRIS are at increased risk for infections due to these organisms, even if they develop antibodies following vaccination.

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SELECT IMPORTANT SAFETY INFORMATION FOR SOLIRIS® (eculizumab) (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Monitoring Disease Manifestations After SOLIRIS Discontinuation

Treatment Discontinuation for aHUS

After discontinuing SOLIRIS, monitor patients with aHUS for signs and symptoms of thrombotic microangiopathy (TMA) complications for at least 12 weeks. In aHUS clinical trials, 18 patients (5 in the prospective studies) discontinued SOLIRIS treatment. TMA complications occurred following a missed dose in 5 patients, and SOLIRIS was reinitiated in 4 of these 5 patients.

Clinical signs and symptoms of TMA include changes in mental status, seizures, angina, dyspnea, or thrombosis. In addition, the following changes in laboratory parameters may identify a TMA complication: occurrence of 2, or repeated measurement of any one of the following: a decrease in platelet count by 25% or more compared to baseline or the peak platelet count during SOLIRIS treatment; an increase in serum creatinine by 25% or more compared to baseline or nadir during SOLIRIS treatment; or, an increase in serum LDH by 25% or more over baseline or nadir during SOLIRIS treatment.

If TMA complications occur after SOLIRIS discontinuation, consider reinstatement of SOLIRIS treatment, plasma therapy [plasmapheresis, plasma exchange, or fresh frozen plasma infusion (PE/PI)], or appropriate organ-specific supportive measures.

Thrombosis Prevention and Management

The effect of withdrawal of anticoagulant therapy during SOLIRIS treatment has not been established. Therefore, treatment with SOLIRIS should not alter anticoagulant management.

Infusion-Related Reactions

Administration of SOLIRIS may result in infusion-related reactions, including anaphylaxis or other hypersensitivity reactions. In clinical trials, no patients experienced an infusion-related reaction which required discontinuation of SOLIRIS. Interrupt SOLIRIS infusion and institute appropriate supportive measures if signs of cardiovascular instability or respiratory compromise occur.

ADVERSE REACTIONS

The most frequently reported adverse reactions in the aHUS single arm prospective trials ($\geq 20\%$) were: headache, diarrhea, hypertension, upper respiratory infection, abdominal pain, vomiting, nasopharyngitis, anemia, cough, peripheral edema, nausea, urinary tract infections, pyrexia.

DRUG INTERACTIONS

Plasmapheresis, Plasma Exchange, or Fresh Frozen Plasma Infusion

Concomitant use of SOLIRIS with plasma exchange (PE), plasmapheresis (PP) or fresh frozen plasma infusion (PE/PI) treatment can reduce serum eculizumab concentrations and requires a supplemental dose of SOLIRIS.

Neonatal Fc Receptor Blockers

Concomitant use of SOLIRIS with neonatal Fc receptor (FcRn) blockers may lower systemic exposures and reduce effectiveness of SOLIRIS. Closely monitor for reduced effectiveness of SOLIRIS.

To report SUSPECTED ADVERSE REACTIONS contact Alexion Pharmaceuticals, Inc. at 1-844-259-6783 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see accompanying full [prescribing information](#) for SOLIRIS, including Boxed WARNING regarding serious and life-threatening or fatal meningococcal infections.

References: 1. Laurence J, Haller H, Mannucci PM, et al. Atypical hemolytic uremic syndrome (aHUS): essential aspects of an accurate diagnosis. *Clin Adv Hematol Oncol*. 2016;11(11):2-15. 2. SOLIRIS. Prescribing Information. Alexion Pharmaceuticals, Inc.