Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

INTRAVENOUS & SUBCUTANEOUS IMMUNE GLOBULINS (IVIG & SCIG)
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

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

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Diagnosis:	Date of Diagnosis:

□ Primary Immunodeficiency	Please specify type of immunodeficiency: □ Bruton's or X-linked Agammaglobunemia □ Common Variable Immunodeficiency (hypogammaglobinemia) □ Congenital Agammaglobulinemia □ Severe Combined Immunodeficiency(SCID) □ Wiskott-Aldrich Syndrome □ X-linked Hyper IgM Syndrome □ Hypergammaglobulinemia types Please provide the member's IgG level:_____ Has the member had at least one bacterial infection directly attributable to this deficiency? □Yes □No

Member Name:	DOB:	Health Plan ID:

Please be sure to complete and include this page with the 1st page of this form.

☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	Has the member's condition been confirmed by electrodiagnostic testing? ☐Yes ☐No *Please submit documentation of the completed EMG report.* Does the member have significant disability in the upper or lower limb? ☐Yes ☐No Please provide Inflammatory Neuropathy Cause and Treatment Scale (INCAT) grade and location measured (i.e. arm or leg): _____
☐ Idiopathic or Immune Thrombocytopenic Purpura (ITP)	Are there any upcoming surgeries or procedures scheduled? ☐Yes ☐ No If yes, please list:_____ Is the member pregnant? ☐Yes ☐ No Has the member previously delivered an infant with autoimmune thrombocytopenia? ☐Yes ☐ No Does the member have acute bleeding? ☐Yes ☐ No Has the member tried corticosteroids? ☐Yes ☐ No If yes, please list medication dates of trial:_____ Please provide the member's platelet count: _____
☐ Myasthenia Gravis Syndrome	Does the member have moderately- to severely-impaired function? ☐Yes ☐ No Has the member previously tried and failed pyridostigmine or neostigmine for at **least 3 months**? ☐Yes ☐ No Has the member previously tried and failed steroids or immunosuppressants for at **least 3 months?** ☐Yes ☐ No Please provide dates of medication trials:_____
☐ Kawasaki Disease	Number of days since illness onset:_____ Type of symptoms: _____ Is disease in the acute phase? ☐Yes Will IVIG be given with aspirin? ☐Yes ☐ No ☐ No If request is for a second dose, did the member fail to respond to initial dose? ☐Yes ☐ No
☐ Chronic B-cell Lymphocytic Leukemia	Does the member have a history of serious bacterial infections requiring antibiotics? ☐Yes ☐ No Please provide the member's IgG level:_____
☐ HIV	Does the member have a history of 2 or more serious bacterial infections during a 1-year period despite receiving highly active antiretroviral therapy and prophylactic antibiotics? ☐Yes ☐ No If yes, please provide the number of infections: _____ Does the member have absence of detectable antibodies to common antigens? ☐Yes ☐ No Does the member have bronchiectasis not responsive to antibiotics and pulmonary therapy? ☐Yes ☐ No Is measles immunization with intramuscular immune globulin contraindicated due to severe thrombocytopenia or coagulation disorder? ☐Yes ☐ No Please provide IgG level (if the member has hypogammaglobulinemia):_____

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Member Name:	DOB:	Health Plan ID:
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☐ Multifocal Motor Neuropathy	Does the member have anti-GM1 antibodies? ☐Yes ☐ No Does the member have conduction block? ☐Yes ☐ No
☐ Guillan-Barre Syndrome	Number of days since onset of neuropathic symptoms:_____ Is this a relapse? ☐Yes ☐No Is the member able to ambulate? ☐Yes ☐No
☐ Dermatomyositis or Polymyositis	Has the diagnosis been confirmed by biopsy? ☐Yes ☐No Has the member previously tried and failed corticosteroids for at least 3 months? ☐Yes ☐No Has the member previously tried and failed azathioprine, methotrexate, or cyclosporine in combination with corticosteroids? ☐Yes ☐No If yes, please provide dates of medication trials:_____
☐ Systemic Lupus Erythematosus (SLE)	Please indicate disease severity: ☐Mild ☐Moderate ☐Severe Has the member previously tried and failed steroids? ☐Yes ☐No Has the member previously tried and failed antimalarials (e.g. hydroxychloroquine)? ☐Yes ☐No Has the member previously tried and failed an immunosuppressant ☐Yes ☐No (e.g. azathioprine methotrexate, cyclosporine)? If yes, please provide dates of medication trials: _____
☐ Multiple Sclerosis (MS)	Is the member experiencing an acute exacerbation? ☐Yes ☐No If yes, has the member previously tried corticosteroids or plasma exchange? ☐Yes ☐No Is IVIG/SCIG being used for maintenance treatment? ☐Yes ☐No If yes, has the member previously tried and failed an interferon for at least 3 months? (e.g. Betaseron, Avonex, Rebif), glatiramer (Copaxone), or fingolimod (Gilenya) ☐Yes ☐No Is the member pregnant? ☐Yes ☐No Is the member immunosuppressed and having frequent infections? ☐Yes ☐No Please provide dates of medication trials:_____
☐ Autoimmune mucocutaneous blistering disease	Was the diagnosis confirmed by biopsy? ☐Yes ☐No Please specify type_____ Has the member previously tried corticosteroids or immunosuppressive agents? ☐Yes ☐No
☐ Parvovirus B19 Infection	Please provide documentation confirming the presence of infection. Does the member have severe anemia associated with immunosuppression? ☐Yes ☐No Please provide hemoglobin level (in g/dL):_____ Does the member have a history of immunodeficiency due to immunosuppressive medications or HIV? ☐Yes ☐No Please provide reticulocyte count (per liter):_____

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☐ Renal and/or Pancreatic Transplant Desensitization in Combination with Rituxan	Will IVIG be given in combination with Rituxan? ☐Yes ☐No Type of organ transplant: ☐Kidney ☐Pancreas Please indicate donor type: ☐Deceased ☐Living If **deceased** donor, please complete the following: Please provide panel reactive antibody (PRA) level (%): _____ Did the member have a previous kidney and/or pancreas transplant? ☐Yes ☐No For **living** donor, please complete the following: Is crossmatch positive? ☐Yes ☐No Is donor-specific antibody positive using Luminex assay? ☐Yes ☐No
☐ Renal Transplant Desensitization Monotherapy	Is the member awaiting a kidney transplant? ☐Yes ☐No
☐ Renal Transplant Rejection	Has the member received a renal transplant from a living donor? ☐Yes ☐No Does the member have post-transplant rejection? ☐Yes ☐No
☐ Allogenic Bone Marrow Transplantation or Hematopoietic Stem Cell Transplantation (HSCT)	Please provide the member's IgG level:_____ For HSCT: please provide the number of days since transplantation:_____ Does the member have a history of recurrent infections? ☐Yes ☐No
☐ Autoimmune Hemolytic Anemia	Please specify type of disease: ☐ warm-type ☐ cold-type Has the member previously tried and failed corticosteroids? ☐Yes ☐No
☐ Stiff-man Syndrome	Does the member have the presence of anti-GAD antibodies? ☐Yes ☐No Has the member previously tried and failed any of the following medications? ☐ Corticosteroids ☐ Benzodiazepines ☐ Immunosuppressants ☐ Gabapentin ☐ Anti-epileptics If yes, please provide names of medications and dates of trials below.

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