



MEDICARE FORM

Immune Globulin (IG) Therapy Medication and/or Infusion Precertification Request

Page 1 of 3

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

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:

Please use other form.

Note: Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma, Gammagard, Gammaked, Gammaplex, Gamunex-C, Hyqvia, Octagam, Panzyga, and Xembify are non-preferred.

The preferred products are Privigen and Hizentra.

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:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Current Weight: _____ lbs or _____ kgs		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: _____

C. PRESCRIBER INFORMATION

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

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: Asceniv Bivigam Cutaquig Cuvitru Flebogamma Gamastan S/D Gammaked
 Gammagard Gammaplex Gamunex-C Hizentra HyQvia Octagam Panzyga Privigen Xembify

Dose: _____ Frequency: _____ HCPCS Code: _____ IV IM SC

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.

Please provide the current immunoglobulin levels:

Immunoglobulin A (IgA) level and date obtained: _____ Date: ____ / ____ / ____

Immunoglobulin G (IgG) level and date obtained: _____ Date: ____ / ____ / ____

Immunoglobulin M (IgM) level and date obtained: _____ Date: ____ / ____ / ____

For All Requests: (Clinical documentation required for all requests)

Note: Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma, Gammagard, Gammaked, Gammaplex, Gamunex-C, Hyqvia, Octagam, Panzyga, and Xembify are non-preferred. The preferred products are Privigen and Hizentra.

Yes No Has the patient had prior therapy with the requested immune globulin product within the last 365 days?

Yes No Has the patient had a trial and failure, intolerance, or contraindication to Privigen or Hizentra?

Please explain if there are any other medical reason(s) that the patient cannot use Privigen or Hizentra.

Yes No Is the patient changing to a different immunoglobulin product?

Yes No Does the patient have immunoglobulin A (IgA) deficiency with anti-IgA antibodies?

Continued on next page



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

For All requests continued: Please indicate which of the following applies to the patient and answer subsequent questions

- Acquired red cell aplasia
- Acute disseminated encephalomyelitis
- Autoimmune mucocutaneous blistering diseases
 - Please select which applies to the patient:
 - Bullous pemphigoid
 - Linear IgA disease
 - Pemphigus vulgaris
 - Epidermolysis bullosa acquisita
 - Mucous membrane pemphigoid (cicatrical pemphigoid)
 - Pemphigus foliaceus
 - Gestational Pemphigoid
 - None of the above
- Yes No Has patient failed conventional therapy?
 - Yes No Does the patient have contraindications to conventional therapy?
 - Yes No Does the patient have rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents?
- Autoimmune hemolytic anemia (refractory)
- Autoimmune neutropenia (refractory)
- B-cell chronic lymphocytic leukemia (CLL)
 - Yes No Does the patient have hypogammaglobulinemia associated with CLL?
 - Yes No Does the patient have recurrent infections or specific antibody deficiency?
- Birdshot (vitiligenous) retinochoroidopathy
- BK virus associated nephropathy
- Chronic inflammatory demyelinating polyneuropathy (CIDP)
 - Yes No Has the patient responded to previous intravenous immune globulin (IVIG) therapy?
- Churg-Strauss Syndrome (CSS) (allergic granulomatosis)
 - Yes No Will IVIG be used as adjunctive therapy for persons with severe active illness?
 - Yes No Have other interventions been unsuccessful, become intolerable, or are contraindicated?
 - Please select which applies: Unsuccessful Intolerable Contraindicated
- Dermatomyositis
 - Yes No Will this be used as adjunctive therapy for persons who have had an inadequate response to first and second line therapies?
- Enteroviral meningoencephalitis
- Guillain-Barre Syndrome (GBS) and GBS variants
 - Yes No Has the patient been diagnosed during the first 2 weeks of illness?
 - Yes No Does the patient require aid to walk? (must be severely affected)
 - Yes No Does the patient have any contraindications to IVIG?
- Hematophagocytic lymphohistiocytosis (HLH) or macrophage activation syndrome (MAS)
 - Yes No Does the patient have hypogammaglobulinemia?
 - Please indicate the IgG level: Less than 400mg/dL 400mg/dl or greater
 - Yes No Is the IgG level two standard deviations below the mean for age?
- Hemolytic disease of newborn
 - Yes No Is this request to decrease the need for exchange transfusion?
- HIV infected children
 - Yes No Is this request for bacterial control or prevention of infection?
- HIV- associated thrombocytopenia (pediatric or adult)
- Hyperimmunoglobulinemia E Syndrome
 - Yes No Is this request for treatment of severe eczema?
- Immune or Idiopathic thrombocytopenic purpura (ITP)
 - Yes No Is a rapid rise in platelet required (such as prior to surgery, to control excessive bleeding, or to defer or avoid splenectomy)?
 - Please provide current platelet count and date collected: _____ Date: ____/____/____
- Kawasaki Disease
- Lambert-Eaton myasthenic syndrome
- Moersch-Woltmann (Stiff-man) syndrome (unresponsive to other therapies)
- Multifocal motor neuropathy
 - Yes No Does the patient have progressive, symptomatic multifocal motor neuropathy?
 - Yes No Was the diagnosis based on electrophysiologic findings that rule out other possible conditions that may not respond to this treatment?
- Multiple Myeloma
- Myasthenia Gravis
- Neonatal Alloimmune Thrombocytopenia (NAIT) (also known as Fetal Alloimmune Thrombocytopenia or FAIT)
- Neonatal Hemochromatosis (prophylaxis)
- Opsoclonus-myooclonus
- Paraneoplastic opsoclonus-myooclonus-ataxia associated with neuroblastoma
- Parvovirus B19 infection (chronic with severe anemia)
- Polymyositis in persons who are resistant to first and second line therapies
- Post-transfusion purpura
- Preparation for thymoma surgery (to prevent myasthenia exacerbation)
- Primary humoral immunodeficiency diseases:

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

Please indicate which of the following applies to the patient:

- Congenital agammaglobulinemia (X-linked agammaglobulinemia)
- X-linked immunodeficiency with hyperimmunoglobulin M
- Immunodeficiency with thymoma (Good Syndrome)
- Rasmussen encephalitis (Rasmussen's Syndrome)
- Relapsing-remitting multiple sclerosis (MS)
 - Yes No Have standard approaches (i.e., interferons) failed, become intolerable, or contraindicated?
 - Please select:* Standard approaches have failed Standard approaches have become intolerable Standard approaches are contraindicated
- Renal transplantation from live donor with ABO incompatibility or positive cross-match
 - Yes No Is a suitable non-reactive live or cadaveric donor unavailable (preparative regimen)?
- Secondary immunosuppression associated with major surgery (such as cardiac transplants) and certain diseases (extensive burns, or collagen-vascular diseases)
- Selective IgG subclass deficiencies with severe infection for persons meeting selection criteria
- Solid organ transplantation
 - Yes No Will IVIG be used for allosensitized members undergoing solid organ transplant?
- Staphylococcal Toxic Shock Syndrome
- Stem cell or bone marrow transplantation
- Systemic lupus erythematosus (SLE) (for persons with severe active SLE)
 - Yes No Have other interventions been unsuccessful, become intolerable, or are contraindicated?
 - Please select:* Unsuccessful Intolerable Contraindicated
- Toxic epidermal necrolysis (Lyell's syndrome) and Steven-Johnson Syndrome
- Toxic shock syndrome or toxic necrotizing fasciitis due to group A streptococcus

For Continuation Requests:(Clinical documentation required for all requests):

- Yes No Has the patient demonstrated an adequate response to therapy? **If Yes**, please send documentation of the patient's progress (include specific significant or life-threatening infections and dates of occurrences as well as the member's current dosage).
- Yes No Has the patient received IVIG within the past 6 months?
 - Yes No Does the patient have a documented severe and/or potentially life-threatening adverse event that occurred during or following the previous infusion?
 - Yes No Could the adverse reaction be managed through pre-medication in the home or office setting?

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.