

IMMUNE GLOBULINS (IVIG)

Prior Authorization Form

(Please be sure to complete and include the 2nd page of this form)

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services. Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

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:	
Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age
Drug Requested (Brand Name REQUIRED) :	Strength:	Frequency:	Diagnosis and ICD9 Code:
Please indicate place of infusion: <input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/Facility <input type="checkbox"/> Patient Home		Please indicate how drug will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE. Provide JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please provide facility/provider name and address: _____			

Please indicate the diagnosis on the left and complete the corresponding questions

<input type="checkbox"/> Primary Immunodeficiency	Please specify type of immunodeficiency: <input type="checkbox"/> Bruton's or X-linked Agammaglobulinemia <input type="checkbox"/> Common Variable Immunodeficiency (hypogammaglobulinemia) <input type="checkbox"/> Congenital Agammaglobulinemia <input type="checkbox"/> Severe Combined Immunodeficiency (SCID) <input type="checkbox"/> Wiskott-Aldrich Syndrome <input type="checkbox"/> X-linked Hyper IgM Syndrome
<input type="checkbox"/> Idiopathic or Immune Thrombocytopenic Purpura (ITP)	Any upcoming surgeries or procedures scheduled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to above, please list surgery/procedure: _____ Is the member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No History of splenectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have acute bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member tried corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to above, please list medication dates of trial: _____ Please provide Platelet count: _____
<input type="checkbox"/> Kawasaki Disease	Is disease in the acute phase? <input type="checkbox"/> Yes <input type="checkbox"/> No If request is for a second dose, did the member fail to respond to initial dose? <input type="checkbox"/> Yes <input type="checkbox"/> No Time frame of illness onset (number of days): _____ Type of symptoms: _____ Will IVIG be given with aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chronic B-cell Lymphocytic Leukemia	Does the member have a history of serious bacterial infections requiring antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No Please provide IgG level: _____
<input type="checkbox"/> HIV	Does the member have a history of serious, recurrent bacterial infections requiring antibiotics despite receiving highly active antiretroviral therapy and prophylactic antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No Please provide IgG level if have hypogammaglobulinemia: _____ Does the member have chronic parvovirus B19 infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have bronchiectasis not responsive to antibiotics and pulmonary therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is measles immunization contraindicated due to severe thrombocytopenia or coagulation disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Guillan-Barre Syndrome	Time frame of onset of neuropathic symptoms (number of days): _____ Is this a relapse? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the member able to ambulate? <input type="checkbox"/> Yes <input type="checkbox"/> No

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IMMUNE GLOBULINS (IVIG)

Page 2

Patient Name

Patient UPMC Health Plan ID Number:

Patient DOB:

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

<input type="checkbox"/> Systemic Lupus Erythematosus (SLE)	Please indicate disease severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Is disease active? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member previously tried and failed NSAIDs (e.g. Naproxen, Ibuprofen)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member previously tried and failed Steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member previously tried and failed antimalarials (e.g. hydroxychloroquine)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member previously tried and failed immunosuppressants (e.g. methotrexate, cyclosporine)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to above, please list medication dates of trial: _____
<input type="checkbox"/> Dermatomyositis or Polymyositis	Has the member previously tried and failed a 4 month trial of Prednisone? <input type="checkbox"/> Yes <input type="checkbox"/> No, Has the member previously tried and failed Azathioprine, Methotrexate, Cyclosporine, or Hydroxychloroquine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to above, please list medication dates of trial: _____
<input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	Does the member have impaired function? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member previously tried and failed Steroid therapy for at least 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to above, please list medication dates of trial: _____ Has the member previously tried and failed plasma exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Multiple Sclerosis (MS)	Specify type: _____ Has the member previously tried and failed an interferon (e.g. Betaseron, Avonex, Rebif) or glatiramer (Copaxone) for at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to above, please list medication dates of trial: _____
<input type="checkbox"/> Autoimmune mucocutaneous blistering disease	Specify type: _____ Has the member previously tried corticosteroids or immunosuppressives agents? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Myasthenia Gravis Syndrome	Does the member have severely impaired function? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member previously tried and failed pyridostigmine or neostigmine for at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member previously tried and failed steroids or immunosuppressants for at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to above, please list medication dates of trial: _____
<input type="checkbox"/> Parvovirus B19 Infection	Does the member have severe anemia associated with bone marrow suppression? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Renal and/or Pancreatic Transplant Desensitization in Combination with Rituxan	Type of organ transplant <input type="checkbox"/> Kidney <input type="checkbox"/> Pancreas Will IVIG be given in combination with Rituxan? <input type="checkbox"/> Yes <input type="checkbox"/> No Please indicate donor type: <input type="checkbox"/> Deceased <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No For living donor, please complete the following: Is crossmatch positive? <input type="checkbox"/> Yes <input type="checkbox"/> No Is donor-specific antibody positive using Luminex assay? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Renal Transplant Desensitization Monotherapy	Is the member awaiting a kidney transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Renal Transplant Rejection	Has the member received a renal transplant from a living donor? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have post-transplant rejection? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Allogenic Bone Marrow Transplantation or Hematopoietic Stem Cell Transplantation (HSCT)	Please indicate IgG level: _____ Does the member have multiple myeloma? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have malignant macroglobulinemia? <input type="checkbox"/> Yes <input type="checkbox"/> No Days post transplant: _____

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