UPMC Health Plan

Intravenous and Subcutaneous Immune Globulins (IVIG and SCIG)

Prior Authorization 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:	Provider NPI #:	
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age
Drug Requested (Brand Name REQUIRED) : ☐ Brand ☐ Generic	Strength:	Frequency:	Diagnosis and ICD9 Code:
☐ New Medication ☐ Ongoing Medication	If ongoing, please provide start date:	If ongoing, has the member shown improvement while on therapy?	☐ Yes ☐ No

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

Please indicate place of infusion: ☐ Physician's office ☐ Hospital/facility ☐ Patient home Please provide facility/provider name and address:	Please indicate how drug will be billed: ☐ Billed directly by the provider via JCODE. Provide JCODE:_____ ☐ Billed by a pharmacy and delivered to the provider ☐ Billed by a pharmacy and delivered to the patient

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

☐ 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
☐ 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): _____

****Gamunex® and Gamunex-C® are the preferred agents for CIDP.****

☐ 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 Has the member had a splenectomy? ☐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: _____

Please be sure to complete and include the 2nd and 3rd pages of this form.

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Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:

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☐ 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	Is disease in the acute phase? ☐Yes ☐No Number of days since illness onset: _____ Type of symptoms: _____ Will IVIG be given with aspirin? ☐Yes ☐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): _____ Please provide CD4 count: _____
☐ 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 (e.g. azathioprine methotrexate, cyclosporine)? ☐Yes ☐No 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 (e.g. Betaseron, Avonex, Rebif), glatiramer (Copaxone), or fingolimod (Gilenya) for at least 3 months? ☐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

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☐ 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): _____
☐ Renal and/or Pancreatic Transplant Desensitization in Combination with Rituxan	Type of organ transplant ☐Kidney ☐Pancreas Will IVIG be given in combination with Rituxan? ☐Yes ☐No 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 ☐ Anti-epileptics ☐ Immunosuppressants ☐ Benzodiazepines ☐ Anti-epileptics ☐ Gabapentin If yes, please provide names of medications and dates of trials: _____

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