



# MEDICARE FORM

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

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(All fields must be completed and legible for Precertification Review.)

For Virginia HMO SNP:  
FAX: 1-833-280-5224  
PHONE: 1-855-463-0933

For other lines of business:  
Please use other form.

**Note: Bivigam, Carimune NF, Cuvitru, Flebogamma, Gammagard, Gammaked, Gammaplex, Gamunex-C, Hyqvia, Octagam, Panzyga are non preferred. The preferred products are Privigen or 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:
Office Contact Name:				Phone:	

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <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: _____	<b>Dispensing Provider/Pharmacy:</b> <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: _____ <b>TIN:</b> _____ <b>PIN:</b> _____
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### E. PRODUCT INFORMATION

Request is for:  Asceniv  Bivigam  Carimune NF  Cutaguig  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: Bivigam, Carimune NF, Cuvitru, Flebogamma, Gammagard, Gammaked, Gammaplex, Gamunex-C, Hyqvia, Octagam, Panzyga are non preferred. The preferred products are Privigen or 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, 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?  
 Yes  No Is this infusion request in an outpatient hospital setting?  
 Yes  No Is the patient medically unstable for infusions at alternate levels of care?  
 Yes  No Does the patient have a clinical history of any cardiopulmonary conditions  
 Yes  No Please provide the description of the condition: \_\_\_\_\_  
 Yes  No Does this condition cause an increased risk of severe adverse reactions?  
 Yes  No Does the patient have documentation of unstable vascular access?  
 Yes  No Does the patient have physical or cognitive impairments such that home infusion would present an unnecessary health risk?  
 Yes  No Please explain: \_\_\_\_\_





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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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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:**

<input type="checkbox"/> Congenital agammaglobulinemia (X-linked agammaglobulinemia)	<input type="checkbox"/> Common variable immunodeficiency	<input type="checkbox"/> Hyper IgM syndromes
<input type="checkbox"/> X-linked immunodeficiency with hyperimmunoglobulin M	<input type="checkbox"/> Hypogammaglobulinemia	<input type="checkbox"/> Wiscott- Aldrich Syndrome
<input type="checkbox"/> Immunodeficiency with thymoma (Good Syndrome)	<input type="checkbox"/> Severe combined immunodeficiency	<input type="checkbox"/> None of the Above

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.