Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Immune Globulin: Intravenous (IVIG) - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for a continuation of therapy with intravenous immune globulin?

☐ Yes ☐ No

Q2. Has the patient demonstrated clinical response to therapy based on an objective clinical measuring tool appropriate to the diagnosis (such as INCAT, Medical Research Council (MRC) muscle strength, 6-MWT, Rankin, Modified Rankin, Activities of Daily Living (ADL) scores)? Must attach documentation.

☐ Yes ☐ No

Q3. Is the requested product being prescribed by or in consultation with a specialist (allergist, immunologist, hematologist, cardiologist, oncologist, or neurologist)?

☐ Yes ☐ No

Q4. Is the request for one of the following products: Bivigam, Flebogamma, Gammagard Liquid, Gammagard S/D, Gammaplex, Gamunex-C, Octagam, Panzyga, or Privigen?

☐ Yes ☐ No

Q5. Is the medication covered under Medicare Part B?

☐ Yes ☐ No

Q6. Does the patient have the diagnosis of autoimmune mucocutaneous blistering disease (e.g,. pemphigus vulgaris, pemphigus folaceus, bullous pemphigoid, mucous membrane [cicatricial] pemphigoid, benign mucous membrane pemphigoid, epidermolysis bullosa acquisita? Must attach documentation.

☐ Yes ☐ No

Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Immune Globulin: Intravenous (IVIG) - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q7. Does the patient meet one of the following: A) inadequate response or inability to tolerate conventional therapy (i.e., steroids, immunosuppressants) OR B) rapidly progressive disease in conjunction with conventional therapy (i.e., steroids, immunosuppressants)? Must attach documentation.

☐ Yes ☐ No

Q8. Does a patient have erythema multiforme major (SJS, TEN) and SCORTEN level 3 or greater? Must attach documentation.

☐ Yes ☐ No

Q9. Does the patient have the diagnosis of scleromyxedema? Must attach documentation.

☐ Yes ☐ No

Q10. Does the patient have the diagnosis of acute idiopathic thrombocytopenia purpura (ITP)? Must attach documentation.

☐ Yes ☐ No

Q11. Does the patient require or have ONE of the following: A) management of acute bleeding, B) need to increase platelet count prior to surgical procedures, C) severe thrombocytopenia (platelets less than 20,000 per microliter), or D) high risk for intracerebral hemorrhage? Must attach documentation.

☐ Yes ☐ No

Q12. Does the patient have a diagnosis of chronic ITP? Must attach documentation.

☐ Yes ☐ No

Q13. Does the patient have ALL of the following: (a) inadequate response or inability to tolerate corticosteroids, (b) duration of illness greater than 6 months, and (c) platelets persistently less than 20,000 per uL? Must attach documentation.

☐ Yes ☐ No

Q14. Does the patient have chronic B-cell lymphocytic leukemia with IgG less than 600 mg/dL and recurrent, serious bacterial infections requiring antibiotic therapy? Must attach documentation.

☐ Yes ☐ No

Q15. Does the patient have a diagnosis of hematopoetic stem cell transplant and IgG less than 400 mg/dL? Must attach documentation.

☐ Yes ☐ No

Q16. Does the patient have a diagnosis of HIV? Must attach documentation.

☐ Yes ☐ No

Q17. Does the patient meet all of the following: A) less than 14 years of age, B) evidence of qualitative or quantitative

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

humoral immunologic defects and C) current bacterial infection despite antimicrobial prophylaxis? Must attach documentation.

☐ Yes ☐ No

Q18. Has the member had a solid organ transplant? Must attach documentation.

☐ Yes ☐ No

Q19. Does the patient have the diagnosis of chronic inflammatory demyelinating polyneuritis confirmed by electrodiagnostic testing or nerve biopsy and an inadequate response or inability to tolerate corticosteroids? Must attach documentation.

☐ Yes ☐ No

Q20. Does the patient have a diagnosis of dermatomyositis or polymyositis diagnosed by laboratory testing (antinuclear or myositis specific antibodies, biopsy, EMG, or MRI) AND inadequate response or inability to tolerate steroids OR immunosuppressants? Must attach documentation.

☐ Yes ☐ No

Q21. Does the patient have the diagnosis of Guillain-Barre syndrome with impaired function (i.e., unable to stand or walk without aid)? Must attach documentation.

☐ Yes ☐ No

Q22. Does the patient have the diagnosis of Lambert Eaton myasthenic syndrome (LEMS) refractory to steroids, immunosuppressants, or cholinesterase inhibitors? Must attach documentation.

☐ Yes ☐ No

Q23. Does the patient have multifocal motor neuropathy diagnosed by electrodiagnostic studies? Must attach documentation.

☐ Yes ☐ No

Q24. Does the patient experience acute exacerbations of multiple sclerosis unresponsive to steroids? Must attach documentation.

☐ Yes ☐ No

Q25. Does the patient have the diagnosis of myasthenia gravis that is refractory to at least 8 weeks of standard therapy (steroids, immunosuppressants, cholinesterase inhibitors)? Must attach documentation.

☐ Yes ☐ No

Q26. Is the patient experiencing myasthenic crisis? Must attach documentation.

☐ Yes ☐ No

Q27. Does the patient have the diagnosis of stiff person syndrome refractory to standard therapy (muscle relaxants,

Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Immune Globulin: Intravenous (IVIG) - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

benzodiazepines, gabapentin)? Must attach documentation.

☐ Yes ☐ No

Q28. Does the patient have a diagnosis of severe, active SLE unresponsive to steroids? Must attach documentation.

☐ Yes ☐ No

Q29. Does the patient have the diagnosis of Kawasaki disease? Must attach documentation.

☐ Yes ☐ No

Q30. Requested Duration:

☐ 3 Months

Q31. Additional Information:

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request