

Gammagard, Gammaked™ & Gamunex®-C Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

Select the diagnosis below:

- | | |
|--|---|
| <input type="checkbox"/> Ataxia-telangiectasia
<input type="checkbox"/> CD40 ligand deficiency (X-linked hyper-IgM syndrome)
<input type="checkbox"/> Common variable immunodeficiency
<input type="checkbox"/> DiGeorge Syndrome
<input type="checkbox"/> IgG subclass deficiency
<input type="checkbox"/> IgA deficiency
<input type="checkbox"/> Nuclear factor of $\kappa\beta$ essential modifier deficiency
<input type="checkbox"/> Other diagnosis: _____ | <input type="checkbox"/> Severe combined immunodeficiency
<input type="checkbox"/> Specific antibody deficiency
<input type="checkbox"/> Transient hypogammaglobulinemia of infancy
<input type="checkbox"/> Unspecified hypogammaglobulinemia
<input type="checkbox"/> Wiskott-Aldrich syndrome
<input type="checkbox"/> X-linked or autosomal recessive agammaglobulinemia |
|--|---|
- ICD-10 Code(s): _____

Please note: Medical notes and labs values must be submitted to support each line checked on this request

Clinical Information:

Is the patient's IgG level less than 500 mg/dL? Yes No

Submission of copy of lab results from past 6 months is required

Will medical records be submitted documenting the patient has recurrent infections and a concurrent diagnosis as above? Yes No

Submission of medical records is required

Does the patient have documented abnormal response to streptococcal vaccines (i.e., 4 fold increase in titers) to protein and polysaccharide antigens? Yes No

Submission of a copy of documentation of administration as well as streptococcal vaccine laboratory titer results at least 4 weeks after administration is required

For IgG subclass deficiency, IgA deficiency specific antibody deficiency, transient hypogammaglobulinemia of infancy or unspecified hypogammaglobulinemia, also answer the following:

Select if the following applies to the patient:

- Significant and clearly documented infectious morbidity such as recurrent pneumonia, frequent episodes of documented bacterial sinusitis (not isolated chronic sinusitis)
- Allergy, anatomic defects, and other causes of increased infection susceptibility have been aggressively treated
- Failure of antimicrobial and anti-inflammatory therapies

Medical notes and labs values must be submitted to support each line checked on this request

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Reauthorization:

If this is a reauthorization request, also answer the following questions:

Is there documentation the patient has history of humoral or combined immunodeficiency with claims for IVIG? Yes No

Submission of documentation showing paid claims for IVIG is required

Is the patient unable to use IVIG due to poor venous access? Yes No

Is the patient/primary caretaker able to self-administer (should not be administered by a home health nurse beyond 1st month)? Yes No

Is there documentation the patient is unable to self-administer and still requires subcutaneous immunoglobulin? Yes No

Submission of chart notes documenting the reason is required

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ Date: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.