

IMMUNE GLOBULINS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Immune Globulins are available on the DHS Pharmacy Services website at
<https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:	NPI:	State license #:	
Facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: <input type="checkbox"/> BIVIGam 10% <input type="checkbox"/> Flebogamma DIF 10% <input type="checkbox"/> Gammaplex 5% <input type="checkbox"/> Octagam 5% <input type="checkbox"/> Carimune NF 6 gm <input type="checkbox"/> Gamastan S-D <input type="checkbox"/> Gammaplex 10% <input type="checkbox"/> Panzyga 10% <input type="checkbox"/> Carimune NF 12 gm <input type="checkbox"/> Gammagard 10% <input type="checkbox"/> Gammar-P <input type="checkbox"/> Privigen 10% <input type="checkbox"/> Cutaquig 16.5% <input type="checkbox"/> Gammagard S-D 5 gm <input type="checkbox"/> Gamunex-C 10% <input type="checkbox"/> Xembify 20% <input type="checkbox"/> Cuvitru 20% <input type="checkbox"/> Gammagard S-D 10 gm <input type="checkbox"/> Hizentra 20% <input type="checkbox"/> other: _____ <input type="checkbox"/> Flebogamma DIF 5% <input type="checkbox"/> Gammaked 10% <input type="checkbox"/> Hyqvia 10%		
List all package sizes requested and quantity for each: Package size to be used: _____ grams Package size to be used: _____ grams Package size to be used: _____ grams # of vials of this package size: _____ vials # of vials of this package size: _____ vials # of vials of this package size: _____ vials		
Total dose per administration:		Route: <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> SQ
Directions/frequency of administration:		Beneficiary's weight: _____ kg
What is the beneficiary's diagnosis?		<i>Submit documentation confirming diagnosis, such as chart notes, lab results, etc.</i>
What is the corresponding diagnosis code?		
For INITIAL requests only: Is the beneficiary's diagnosis and prescribed dose listed in either the agent's package insert OR nationally recognized compendia of medically-accepted indications for off-label uses?		<input type="checkbox"/> Yes <input type="checkbox"/> No – <i>Submit documentation of peer-reviewed medical literature supporting the use/dose of the requested agent for the beneficiary's diagnosis.</i>
For RENEWAL requests only: Since the requested medication was started, has the beneficiary experienced a positive clinical response to therapy?		<input type="checkbox"/> Yes – <i>Submit documentation of response.</i> <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
------------------------------	--------------

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.