BlueCross BlueShield
Federal Employee Program

Prior Authorization Request Form	IVIG IMMUNE GLOBULIN

Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: The Federal Employee Program has a 15 Day turn-around time on all Prior Authorization Requests According to the Blue Cross Blue Shield Service Benefit Plan
Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Provider Information	Patient Information
Servicing Provider/Vendor/Lab's Name and Address: **Tax ID Number:** **NPI:**	**Patient's Name:** **Birth Date:**
Referring/Prescribing Physician's Name: ☐ **PCP;** ☐ **Specialist:** **PLEASE IDENTIFY SPECIALTY**	**Blue Shield ID Number:**
Servicing Facility Name and Address: **Tax ID Number:** **NPI:**	**Place of Service:** ☐**Physician's Office** ☐**Freestanding Ambulatory Surgery Center** ☐**Patient's Home** ☐**Home Care Agency** ☐**Outpatient Hospital Care** ☐ **Long Term Care** ☐**Inpatient Hospital Care** ☐**Other (explain):** _____
Office Contact:	
Phone: ( )	
Fax: ( )	**Anticipated Date of Service:**

Please enter all codes requested; "by report" codes must have a description of why the code is being used

ICD-10 CODE(S):

CPT CODE(S):

HCPCS CODE(S):

PATIENT CLINICAL INFORMATION

Please select medication:

☐ **Bivigam** ☐ **Carimune NF** ☐ **Flebogamma** ☐ **Gammagard** ☐ **Gammagard S/D**
☐ **Gammaked** ☐ **Gammaplex** ☐ **Gamunex-C** ☐ **Octagam** ☐ **Privigen**

PHYSICIAN COMPLETES

1. Has the patient been on the requested medication continuously for the last **6 months,** excluding samples?

❑ **YES** – this is a renewal PA for the **CONTINUATION of** therapy, please proceed to **PAGES 5 AND 6**

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions below:

❑ **INITIATION of** therapy, please answer the following questions:

a. Will the medication be self-administered? ❑Yes ❑No
b. Will the patient be monitored carefully for signs and symptoms of thrombosis during and after infusion? ❑Yes ❑No
c. Has the patient or caregiver been instructed on how to monitor for signs and symptoms of thrombosis? ❑Yes ❑No
d. What is the patient's **diagnosis**?

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- ❑ **Autoimmune encephalitis**
- ❑ **Inclusion-body myositis**
- ❑ **Lambert-Eaton Mysathenic Syndrome (LEMS)**
- ❑ **Neoplastic disease**
- ❑ **Peripheral Blood Progenitor Cell (PBPC) collection**
- ❑ **Fetal Alloimmune Thrombocytopenia (F/NAIT)**
- ❑ **Kawasaki syndrome**
- ❑ **Multiple sclerosis**
- ❑ **Parvovirus B 19-induced pure Red Cell Aplasia (PRCA)**
- ❑ **Umbilical cord stem cell transplantation**

❑ **Bone marrow Transplantation (BMT) OR Hematopoietic stem cell transplant (HSCT) recipients**

1. Is the patient a recipient of a BMT or HSCT? ❑ **BMT recipient** ❑ **HSCT recipient**
2. Is the medication being prescribed for prophylaxis of bacterial and viral infections? ❑Yes ❑No
3. Has the patient received a transplant in the last 100 days? ❑Yes ❑No*

***If NO**, does the patient have a pre-treatment serum lgG level less than 400 mg/dL? ❑Yes ❑No

❑ **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)**

1. Does the patient have moderate to severe functional disability? ❑Yes ❑No
2. Has the patient had electro-diagnostic studies (example: EMG, NCV) that are consistent with multifocal demyelinating abnormalities? ❑Yes ❑No

❑ **Chronic Lymphocytic Leukemia (CLL)**

1. Does the patient have B-cell type Chronic Lymphocytic Leukemia (CLL)? ❑Yes ❑No
2. Is the medication being prescribed for prophylaxis of bacterial and viral infections?
3. Is there a documented history of recurrent sinopulmonary infections requiring intravenous antibiotics or hospitalization? ❑Yes ❑No
4. Does the patient have a pre-treatment serum lgG level less than 500 mg/dL? ❑Yes ❑No

❑ **Dermatomyositis OR Polymyositis**

1. Does the patient have a diagnosis of dermatomyositis or polymyositis? ❑ **Dermatomyositis** ❑ **Polymyositis**
2. Does the patient have documented clinical features such as: elevated muscle enzymes, muscle biopsy or supportive diagnostic tests? ❑Yes ❑No
3. Has the patient had an inadequate response intolerance or contraindication to first-line treatments such as: corticosteroids or immunosuppressants? ❑Yes ❑No

❑ **Guillain-Barre Syndrome (GBS)**

1. Has the patient's physical mobility been severely affected requiring the patient to use an aid to walk? ❑Yes ❑No
2. Will IVIG therapy be initiated within two weeks of the onset of symptoms? ❑Yes ❑No

❑ **HIV infections**

1. Is the medication being prescribed for prophylaxis of bacterial and viral infections? ❑Yes ❑No
2. Has the patient received treatment for HIV? ❑Yes ❑No
3. Does the patient have a pre-treatment serum lgG level less than 400 mg/dL? ❑Yes ❑No
4. Does the patient have documentation of recurrent bacterial and viral infections (greater than two serious infections in a year)? ❑Yes ❑No
5. Does the patient have a contraindication to taking combination antiretroviral therapy? ❑Yes ❑No
6. Has antibiotic prophylaxis been found to be ineffective for this patient? ❑Yes ❑No

❑ **Multifocal Motor Neuropathy (MMN)**

1. Is the patient experiencing weakness without objective sensory loss* in 2 or more nerves?

Objective sensory loss is defined as: decreased reflexes, motor weakness, muscle wasting, trophic skin, and joint changes

2. Has the patient had electrodiagnostic studies that are consistent with motor conduction block? ❑Yes ❑No
3. Has the patient had sensory nerve conduction studies that are normal? ❑Yes ❑No

❑ **Myasthenia gravis**

1. Has the patient experienced an increase in any of the following symptoms: diplopia (double vision), ptosis (drooping eyelid), blurred vision, dysarthria (difficulty in speech), dysphagia (difficulty swallowing), difficulty chewing, impaired respiratory status, fatigue, or limb weakness? ❑Yes ❑No
2. Has the patient had pre-operative management*? ❑Yes ❑No

Pre-operative management includes: cholinesterase inhibitors, corticosteroids or immunosuppressants

❑ **Stiff-person syndrome**

1. Has the patient had an inadequate response, intolerance or contraindication to first-line treatment*? ❑Yes ❑No
   Examples of first-line treatment: benzodiazepine and baclofen

❑ **Idiopathic Thrombocytopenic Purpura (ITP)**

1. **FEMALE** patient: is the patient pregnant? ❑Yes ❑No
2. Was the patient diagnosed within the last 3 months? ***(please select answer below):***

❑ **Yes: Please Complete A** for patients **under the age of 18 OR Complete B** for patients **18 years of age or older**

A. Patients UNDER 18 years of age, please select **ONE** of the following:

❑ Patient has significant bleeding symptoms such as mucosal bleeding or moderate to severe bleeding
❑ Patient is at high risk for bleeding
❑ Patient require a rapid increase in platelets due to a surgery or procedure
❑ None of the above

OR

B. Patients 18 years of age or older, please answer the following question:

i. Will IVIG be used in combination with corticosteroid therapy? ❑Yes ❑No*
   ***If NO**, does the patient have a contraindication to corticosteroid therapy? ❑Yes ❑No

ii. Please select **ONE** of the following:

❑ **Patient's platelet count is less than 30,000/mcL**
❑ **Patient's platelet count is 30,000/mcL to 49,999/mcL**, please answer the following question:
   a. Does the patient have significant bleeding symptoms, a high risk for bleeding or a requirement for a rapid increase in platelets? ❑Yes ❑No
❑ **Patient's platelet count is 50,000/mcL or greater**

❑ **No**: Please answer the questions below:

a. Is the patient experiencing refractory ITP following a splenectomy? ❑Yes ❑No
b. Has the patient had a relapse after a previous response to IVIG? ❑Yes ❑No
c. Has the patient had inadequate response, intolerance or contraindication to corticosteroid therapy? ❑Yes ❑No
d. Please select **ONE** of the following:

❑ **Patient's platelet count is less than 30,000/mcL**, please answer the following question:
   i. Does the patient have significant bleeding symptoms? ❑Yes ❑No
❑ **Patient's platelet count is 30,000/mcL to 49,999/mcL**, please answer the following question:
   i. Does the patient have significant bleeding or is at high risk for bleeding or have a requirement for a rapid increase in platelets? ❑Yes ❑No
❑ **Patient's platelet count is 50,000/mcL or greater**

❑ **Primary Immunodeficiency Disease (PID)**

1. What type of PID does the patient have? Please select **ONE** of the following types of PID below:

❑ **Agammaglobulinemia OR Severe Combined Immunodeficiency Disease (SCID)**

a. Does the patient have a confirmed diagnosis by genetic or molecular testing? ❑Yes ❑No
b. Does the patient have a pre-treatment IgG less than 200 mg/dL? ❑Yes ❑No
c. What type of PID does the patient have?
❑ **Agammaglobulinemia** ❑ **SCID**
d. **SCID diagnosis**: does the patient have an absence or very low number of T cells (CD3 T cells less than 300/microliter)? ❑Yes ❑No*
   ***If NO**, is there a presence of maternal T cells in the circulation? ❑Yes ❑No

❑ **Ataxia-telangiectasia, DiGeorge syndrome, Wiskott-Aldrich syndrome, or other non-SCID combined immunodeficiency** ***(please answer the following questions):***

a. Has the patient's diagnosis been confirmed by genetic or molecular testing? ❑Yes ❑No
b. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No
d. What type of PID does the patient have? ***(please select one of the following)***
❑ **Ataxia-telangiectasia** ❑ **DiGeorge syndrome** ❑ **Wiskott-Aldrich syndrome**
❑ **Other non-SCID combined immunodeficiency** ***(please specify):*** __

❑ **Common Variable Immunodeficiency Disease (CVID)**

a. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No
b. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No
c. Have other causes of immune deficiency been excluded including: drug-induced, genetic disorders, infectious diseases such as HIV or malignancy? ❑Yes ❑No
d. Does the patient have a pre-treatment lgG level of less than 500 mg/dL? ❑Yes ❑No*
***If NO**, does the patient have a pre-treatment lgG equivalent to 2 or more standard deviations below the mean for the age of the patient? ❑Yes ❑No

❑ **Hypogammaglobulinemia, lgG subclass deficiency, Selective lgA deficiency, Selective lgM deficiency, or Specific antibody deficiency** ***(please answer the following questions):***

a. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No
b. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No
c. Please select the type of PID the patient has and answer the following question:

❑ **Hypogammaglobulinemia**, please answer the following question:
i. Does the patient have an lgG less than 500 mg/dL? ❑Yes ❑No*
***If NO**, does the patient have a pre-treatment lgG equivalent to 2 or more standard deviations below the mean for the patient's age? ❑Yes ❑No

❑ **lgG subclass deficiency**, please answer the following questions:
i. Does the patient have an lgG1, lgG2, or lgG3 equivalent to 2 or more standard deviations below the mean for the patient's age on at least two occasions? ❑Yes ❑No
ii. Does the patient have lgG (total) and lgM levels within normal limits? ❑Yes ❑No
iii. Does the patient have lgA levels within low to normal limits? ❑Yes ❑No

❑ **Selective lgA deficiency**: does the patient have an lgA level less than 7 mg/dL with normal lgG and lgM levels? ❑Yes ❑No

❑ **Selective lgM deficiency**: does the patient have an lgM level less than 30mg/dL with normal lgG and lgA levels? ❑Yes ❑No

❑ **Specific antibody deficiency**: does the patient have lgA, lgG, lgM levels within normal limits? ❑Yes ❑No

❑ Other diagnosis ***(please specify):*** _____

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PLEASE ANSWER THE FOLLOWING QUESTIONS FOR CONTINUATION OF THERAPY

Please select medication:

☐ **Bivigam** ☐ **Carimune NF** ☐ **Flebogamma** ☐ **Gammagard** ☐ **Gammagard S/D**
☐ **Gammaked** ☐ **Gammaplex** ☐ **Gamunex-C** ☐ **Octagam** ☐ **Privigen**

1. Has the patient been on the requested medication continuously for the last **6 months**, excluding samples?
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the questions on **PAGES 1-4**
   - ❑ **YES** – this is a renewal PA for the **CONTINUATION** of therapy, please answer the questions below:

❑ **CONTINUATION** (renewal PA) of therapy, please answer the following questions:

1. What is the patient **diagnosis**?

❑ **Autoimmune encephalitis**
❑ **Guillain-Barre Syndrome (GBS)**
❑ **Inclusion-body myositis**
❑ **Lambert-Eaton Myasthenic Syndrome (LEMS)**
❑ **Myasthenia gravis**
❑ **Parvovirus B19-induced pure Red Cell Aplasia (PRCA)**
❑ **Stiff-person syndrome**
❑ **Fetal Alloimmune Thrombocytopenia (F/NAIT)**
❑ **Idiopathic Thrombocytopenic Purpura (ITP)**
❑ **Kawasaki syndrome**
❑ **Multiple sclerosis**
❑ **Neoplastic disease**
❑ **Peripheral Blood Progenitor Cell (PBPC) collection**
❑ **Umbilical cord stem cell transplantation**

❑ **Bone Marrow Transplantation (BMT) OR Hematopoietic Stem Cell Transplantation (HSCT) recipients**
a. Is the patient a recipient of a BMT or HSCT? ❑ **BMT recipient** ❑ **HSCT recipient**
b. Is the medication being prescribed for prophylaxis of bacterial and viral infections? ❑Yes ❑No
c. Does the patient have a documented reduction of frequency of bacterial and viral infections since initiation?
❑Yes ❑No

❑ **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)**
a. Is the IVIG being used at the lowest effective dose and frequency? ❑Yes ❑No
b. Have chronic stable patients been tapered and/or had treatment withdrawn to determine whether continued treatment is
necessary? ❑Yes ❑No
c. Has the patient had a significant improvement in disability and maintenance of improvement since initiation ?
❑Yes ❑No

❑ **Chronic Lymphocytic Leukemia (CLL)**
a. Does the patient have B-cell Chronic Lymphocytic Leukemia (CLL)? ❑Yes ❑No
b. Does the patient have a documented reduction of frequency of bacterial and viral infections since initiation?
❑Yes ❑No

❑ **Dermatomyositis OR Polymyositis**
a. Does the patient have a diagnosis of dermatomyositis or polymyositis? ❑ **Dermatomyositis** ❑ **Polymyositis**
b. Has the patient had a significant improvement in disability and maintenance of improvement since initiation?
❑Yes ❑No

❑ **HIV infections**
a. Is the medication being prescribed for prophylaxis of bacterial and viral infections? ❑Yes ❑No
b. Does the patient have a documented reduction of frequency of bacterial and viral infections since initiation?
❑Yes ❑No

❑ **Multifocal Motor Neuropathy (MMN)**
a. Has the patient had a significant improvement in disability and maintenance of improvement since initiation?
❑Yes ❑No

❑ **Primary Immunodeficiency Disease (PID)**
a. What type of Primary Immunodeficiency Disease (PID) does the patient have?
(please select ONE of the following)

❑Agammaglobulinemia ❑Ataxia-telangiectasia ❑Common Variable Immunodeficiency Disease (CVID)
❑DiGeorge syndrome ❑Hypogammaglobulinemia ❑IgG subclass deficiency
❑Selective IgA deficiency ❑Selective IgM deficiency ❑Severe Combined Immunodeficiency Disease (SCID)
❑Specific antibody deficiency ❑Wiskott-Aldrich syndrome

❑Other non-SCID combined immunodeficiency ***(please specify)***: _____

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❑Other immune deficiency ***(please specify)***: _____

b. Are lgG trough levels monitored at least yearly and maintained at or above the lower range of normal for age? ❑Yes ❑No c. Does the patient have a documented reduction of frequency of bacterial and viral infections since initiation? ❑Yes ❑No

d. Does the prescriber agree to re-evaluate the dose and reconsider a dose adjustment? ❑Yes ❑No

❑ Other diagnosis ***(please specify):*** _____

Prescriber's NPI	Physician Signature	Date

View our Medical Policy on line at http://www.fepblue.org/medical-policies.jsp