

### IMMUNE GLOBULINS PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for Immune Globulins, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Immune Globulins (accessible at: <http://www.dhs.state.pa.us/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

| <u>PRIOR AUTHORIZATION REQUEST INFORMATION</u>   |      | <u>PRESCRIBER INFORMATION</u> |                  |
|--|------|-------------------------------|------------------|
| <input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____)<br><input type="checkbox"/> Renewal request      # of pages in request: _____ |      | Prescriber name:              |                  |
| Name of office contact:  |      | Specialty:                    |                  |
| Contact's phone number:  |      | State license #:              |                  |
| Facility contact/phone:  |      | NPI:                          | MA Provider ID#: |
| <u>RECIPIENT INFORMATION</u>   |      | Street address:               |                  |
| Recipient Name:  |      | Suite #:                      | City/state/zip:  |
| Recipient ID#:   | DOB: | Phone:                        | Fax:             |

### CLINICAL INFORMATION

|   |  |  |  |
|---|--|--|--|
| <b>Medication requested:</b>  |  |  |  |
| <input type="checkbox"/> BIVIGam 10%  | <input type="checkbox"/> Gammagard S-D 5 gm  | <input type="checkbox"/> Gammaplex 5%  | <input type="checkbox"/> Gamunex-C 40 gm   |
| <input type="checkbox"/> Carimune NF 6 gm   | <input type="checkbox"/> Gammagard S-D 10 gm | <input type="checkbox"/> Gammar-P  | <input type="checkbox"/> Hizentra 1 gm   |
| <input type="checkbox"/> Carimune NF 12 gm  | <input type="checkbox"/> Gammaked 1 gm       | <input type="checkbox"/> Gamunex-C 1 gm  | <input type="checkbox"/> Hizentra 2 gm   |
| <input type="checkbox"/> Flebogamma DIF 5%  | <input type="checkbox"/> Gammaked 2.5 gm     | <input type="checkbox"/> Gamunex-C 2.5 gm  | <input type="checkbox"/> Hizentra 4 gm   |
| <input type="checkbox"/> Flebogamma DIF 10%   | <input type="checkbox"/> Gammaked 5 gm       | <input type="checkbox"/> Gamunex-C 5 gm  | <input type="checkbox"/> Hizentra 10 gm  |
| <input type="checkbox"/> Gamastan S-D   | <input type="checkbox"/> Gammaked 10 gm      | <input type="checkbox"/> Gamunex-C 10 gm   | <input type="checkbox"/> Octagam 5%  |
| <input type="checkbox"/> Gammagard 10%  | <input type="checkbox"/> Gammaked 20 gm      | <input type="checkbox"/> Gamunex-C 20 gm   | <input type="checkbox"/> Privigen 10%  |
| <input type="checkbox"/> other: _____   |  |  |  |
| Strength: _____ gm / %  | Quantity: _____ ml / vials                   | Route: <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> SQ |  |
| Duration of therapy:  | Directions:                                  | Recipient's weight: _____ kg   |  |
| 1. What is the Recipient's diagnosis?   |  | <i>Submit documentation confirming diagnosis, such as chart notes, lab results, etc.</i>   |  |
| 2. What is the corresponding diagnosis code?  |  |  |  |
| 3. Immune Globulins are part of the Department's Specialty Pharmacy Drug Program (SPDP). What Specialty Pharmacy will be used? (Refer to the Department's SPDP website for more information: <a href="http://www.dhs.pa.gov/provider/pharmacyservices/thespecialtypharmacydrugprogram/index.htm">http://www.dhs.pa.gov/provider/pharmacyservices/thespecialtypharmacydrugprogram/index.htm</a> .) |  |  | <input type="checkbox"/> Diplomat Specialty Pharmacy<br><input type="checkbox"/> Walgreens Specialty Pharmacy  |
| 4. <b>For INITIAL requests only:</b> Is the Recipient'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<br><input type="checkbox"/> No – <i>submit documentation of peer-reviewed medical literature supporting the use/dose of the requested agent for the Recipient's diagnosis</i> |
| 5. <b>For RENEWAL requests only:</b> Since the requested medication was started, has the Recipient experienced a positive clinical response to therapy?   |  |  | <input type="checkbox"/> Yes – <i>submit documentation of response</i><br><input type="checkbox"/> No  |

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

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

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