MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

INTRAVENOUS & SUBCUTANEOUS IMMUNE GLOBULINS (IVIG & SCIG)
Prior Authorization Form

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Diagnosis:	Date of Diagnosis:

□ Primary Immunodeficiency	Please provide the member's IgG level:_____ Date of IgG level: _____ For initial authorization if IgG level is 500mg/dL or greater please provide clinical rationale for use either in a chart note or at the space at the end of the form. Has the member had at least one bacterial infection directly attributable to this deficiency? □Yes □No

☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	Has the member's condition been confirmed by electrodiagnostic testing? ☐Yes ☐No *Please submit documentation of this testing*
☐ Idiopathic or Immune Thrombocytopenic Purpura (ITP)	Are there any upcoming surgeries or procedures scheduled? ☐Yes ☐ No If yes, please list:_____ Is the member pregnant? ☐Yes ☐ No Has the member previously delivered an infant with autoimmune thrombocytopenia? ☐Yes ☐ No Does the member have acute mucous membrane bleeding? ☐Yes ☐ No Has the member tried corticosteroids? ☐Yes ☐ No If yes, please list medications and response:_____ Does the patient have history of splenectomy? ☐Yes ☐ No Please provide the member's current platelet count: _____
☐ Chronic B-cell Lymphocytic Leukemia	Does the member have a history of serious bacterial infections requiring antibiotics? ☐Yes ☐ No Please provide the member's IgG level:_____
☐ Multifocal Motor Neuropathy	Does the member have progressive symptomatic disease diagnosed by electrophysiologic findings to rule out other conditions? ☐Yes ☐ No Does the member have a conduction block? ☐Yes ☐ No

History of Medications Used to Treat Above Condition

☐ No other medications have been used to treat this condition

Medication	Strength	Directions	Dates of Therapy		Reason for Discontinuing
			Start	End	

Please provide any additional information which should be considered in the space below: