aetna®

MEDICARE FORM

Immune Globulin (IG) Therapy Medication and/or Infusion Precertification Request

(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

For other lines of business:
Please use other form.

Note: Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma, Gammagard, Gammaked, Gammaplex, Gamunex-C, Hyqvia, Octagam, Panzyga, and Xembify are non-preferred. The preferred products are Privigen and Hizentra.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:			

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Asceniv** ☐ **Bivigam** ☐ **Cutaguig** ☐ **Cuvitru** ☐ **Flebogamma** ☐ **Gamastan S/D** ☐ **Gammaked**
☐ **Gammagard** ☐ **Gammaplex** ☐ **Gamunex-C** ☐ **Hizentra** ☐ **HyQvia** ☐ **Octagam** ☐ **Panzyga** ☐ **Privigen** ☐ **Xembify**

Dose: _____ **Frequency:** _____ **HCPCS Code:** _____ ☐ **IV** ☐ **IM** ☐ **SC**

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

Please provide the current immunoglobulin levels:
Immunoglobulin A (IgA) level and date obtained: _____ Date: ____/____/____
Immunoglobulin G (IgG) level and date obtained: _____ Date: ____/____/____
Immunoglobulin M (IgM) level and date obtained: _____ Date: ____/____/____

For All Requests: (Clinical documentation required for all requests)
Note: Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma, Gammagard, Gammaked, Gammaplex, Gamunex-C, Hyqvia, Octagam, Panzyga, and Xembify are non-preferred. The preferred products are Privigen and Hizentra.

☐ Yes ☐ No Has the patient had prior therapy with the requested immune globulin product within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to Privigen or Hizentra?
Please explain if there are any other medical reason(s) that the patient cannot use Privigen or Hizentra.

_____

☐ Yes ☐ No Is the patient changing to a different immunoglobulin product?
☐ Yes ☐ No Does the patient have immunoglobulin A (IgA) deficiency with anti-IgA antibodies?

Continued on next page

aetna®

MEDICARE FORM

Immune Globulin (IG) Therapy Medication and/or Infusion Precertification Request

(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

For other lines of business:
Please use other form.

Note: Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma, Gammagard, Gammaked, Gammaplex, Gamunex-C, Hyqvia, Octagam, Panzyga, and Xembify are non-preferred. The preferred products are Privigen and Hizentra.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For All requests continued: *Please indicate which of the following applies to the patient and answer subsequent questions*

☐ Acquired red cell aplasia

☐ Acute disseminated encephalomyelitis

☐ Autoimmune mucocutaneous blistering diseases

Please select which applies to the patient: ☐ Bullous pemphigoid ☐ Epidermolysis bullosa acquisita ☐ Gestational Pemphigoid ☐ Linear IgA disease ☐ Mucous membrane pemphigoid (cicatrical pemphigoid) ☐ Pemphigus vulgaris ☐ Pemphigus foliaceus ☐ None of the above

☐ Yes ☐ No Has patient failed conventional therapy?

→ ☐ Yes ☐ No Does the patient have contraindications to conventional therapy?

→ ☐ Yes ☐ No Does the patient have rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents?

☐ Autoimmune hemolytic anemia (refractory)

☐ Autoimmune neutropenia (refractory)

☐ B-cell chronic lymphocytic leukemia (CLL)

☐ Yes ☐ No Does the patient have hypogammaglobulinemia associated with CLL?

☐ Yes ☐ No Does the patient have recurrent infections or specific antibody deficiency?

☐ Birdshot (vitiligenous) retinochoroidopathy

☐ BK virus associated nephropathy

☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)

☐ Yes ☐ No Has the patient responded to previous intravenous immune globulin (IVIG) therapy?

☐ Churg-Strauss Syndrome (CSS) (allergic granulomatosis)

☐ Yes ☐ No Will IVIG be used as adjunctive therapy for persons with severe active illness?

☐ Yes ☐ No Have other interventions been unsuccessful, become intolerable, or are contraindicated?

→ Please select which applies: ☐ Unsuccessful ☐ Intolerable ☐ Contraindicated

☐ Dermatomyositis

☐ Yes ☐ No Will this be used as adjunctive therapy for persons who have had an inadequate response to first and second line therapies?

☐ Enteroviral meningoencephalitis

☐ Guillain-Barre Syndrome (GBS) and GBS variants

☐ Yes ☐ No Has the patient been diagnosed during the first 2 weeks of illness?

☐ Yes ☐ No Does the patient require aid to walk? (must be severely affected)

☐ Yes ☐ No Does the patient have any contraindications to IVIG?

☐ Hematophagocytic lymphohistiocytosis (HLH) or macrophage activation syndrome (MAS)

☐ Yes ☐ No Does the patient have hypogammaglobulinemia?

→ Please indicate the IgG level: ☐ Less than 400mg/dL ☐ 400mg/dl or greater

☐ Yes ☐ No Is the IgG level two standard deviations below the mean for age?

☐ Hemolytic disease of newborn

☐ Yes ☐ No Is this request to decrease the need for exchange transfusion?

☐ HIV infected children

☐ Yes ☐ No Is this request for bacterial control or prevention of infection?

☐ HIV- associated thrombocytopenia (pediatric or adult)

☐ Hyperimmunoglobulinemia E Syndrome

☐ Yes ☐ No Is this request for treatment of severe eczema?

☐ Immune or Idiopathic thrombocytopenic purpura (ITP)

☐ Yes ☐ No Is a rapid rise in platelet required (such as prior to surgery, to control excessive bleeding, or to defer or avoid splenectomy)?

→ Please provide current platelet count and date collected: _____ Date: ____/____/____

☐ Kawasaki Disease

☐ Lambert-Eaton myasthenic syndrome

☐ Moersch-Woltmann (Stiff-man) syndrome (unresponsive to other therapies)

☐ Multifocal motor neuropathy

☐ Yes ☐ No Does the patient have progressive, symptomatic multifocal motor neuropathy?

☐ Yes ☐ No Was the diagnosis based on electrophysiologic findings that rule out other possible conditions that may not respond to this treatment?

☐ Multiple Myeloma ☐ Myasthenia Gravis ☐ Neonatal Alloimmune Thrombocytopenia (NAIT) (also known as Fetal Alloimmune Thrombocytopenia or FAIT)

☐ Neonatal Hemochromatosis (prophylaxis) ☐ Opsoclonus-myoclonus ☐ Paraneoplastic opsoclonus-myoclonus-ataxia associated with neuroblastoma

☐ Parvovirus B19 infection (chronic with severe anemia) ☐ Polymyositis in persons who are resistant to first and second line therapies

☐ Post-transfusion purpura ☐ Preparation for thymoma surgery (to prevent myasthenia exacerbation) ☐ Primary humoral immunodeficiency diseases:

Continued on next page

aetna®

MEDICARE FORM

Immune Globulin (IG) Therapy Medication and/or Infusion Precertification Request

(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

For other lines of business:
Please use other form.

Note: Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma, Gammagard, Gammaked, Gammaplex, Gamunex-C, Hyqvia, Octagam, Panzyga, and Xembify are non-preferred. The preferred products are Privigen and Hizentra.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

Please indicate which of the following applies to the patient:

- ☐ Congenital agammaglobulinemia (X-linked agammaglobulinemia)
- ☐ Common variable immunodeficiency
- ☐ Hyper IgM syndromes
- ☐ X-linked immunodeficiency with hyperimmunoglobulin M
- ☐ Hypogammaglobulinemia
- ☐ Wiscott- Aldrich Syndrome
- ☐ Immunodeficiency with thymoma (Good Syndrome)
- ☐ Severe combined immunodeficiency
- ☐ None of the Above

☐ Rasmussen encephalitis (Rasmussen's Syndrome)

☐ Relapsing-remitting multiple sclerosis (MS)
- ☐ Yes ☐ No Have standard approaches (i.e., interferons) failed, become intolerable, or contraindicated?
  Please select: ☐ Standard approaches have failed ☐ Standard approaches have become intolerable ☐ Standard approaches are contraindicated

☐ Renal transplantation from live donor with ABO incompatibility or positive cross-match
- ☐ Yes ☐ No Is a suitable non-reactive live or cadaveric donor unavailable (preparative regimen)?

☐ Secondary immunosuppression associated with major surgery (such as cardiac transplants) and certain diseases (extensive burns, or collagen-vascular diseases)

☐ Selective IgG subclass deficiencies with severe infection for persons meeting selection criteria

☐ Solid organ transplantation
- ☐ Yes ☐ No Will IVIG be used for allosensitized members undergoing solid organ transplant?

☐ Staphylococcal Toxic Shock Syndrome

☐ Stem cell or bone marrow transplantation

☐ Systemic lupus erythematosus (SLE) (for persons with severe active SLE)
- ☐ Yes ☐ No Have other interventions been unsuccessful, become intolerable, or are contraindicated?
  → Please select: ☐ Unsuccessful ☐ Intolerable ☐ Contraindicated

☐ Toxic epidermal necrolysis (Lyell's syndrome) and Steven-Johnson Syndrome

☐ Toxic shock syndrome or toxic necrotizing fasciitis due to group A streptococcus

For Continuation Requests:(Clinical documentation required for all requests):

☐ Yes ☐ No Has the patient demonstrated an adequate response to therapy? **If *Yes***, please send documentation of the patient's progress (include specific significant or life-threatening infections and dates of occurrences as well as the member's current dosage).

☐ Yes ☐ No Has the patient received IVIG within the past 6 months?
- → ☐ Yes ☐ No Does the patient have a documented severe and/or potentially life-threatening adverse event that occurred during or following the previous infusion?
  - → ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the home or office setting?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.