

Prior Authorization Form



NOTE: Refer to the Provider Manual for additional services requiring **Prior Authorization**

Fax Form To: Grand Rapids – 616 942-0024 Holland – 616 392-7626 ASO – 616 395-4090 Traverse City – 231 932-9505 Farmington Hills – 800 289-6744

Intravenous Immunoglobulin (IVIG)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____

Plan/Product Type: EPO HMO POS SF-POS PPO Medicaid Medicare

Primary Care Physician: _____ PCP Phone: _____ PCP Fax: _____

Has PCP been notified of request? Yes No _____

Requested By:

Provider Name: _____ Phone: _____ Fax: _____

Address: _____ Contact Name: _____

_____ Date of Request: _____

Indications for Medical Necessity:

1. Please provide diagnosis: _____

2. ICD9 code: _____

3. Please provide a list of all other therapies that this patient has tried and failed for this diagnosis, with duration and outcome:

4. Please provide the following:

a. patient's weight: _____

b. patient's trough IgG level: _____

date: _____

c. target dose(g/kg or mg/kg): _____

d. dosing frequency: _____

e. duration: _____

f. route of administration: _____

g. facility: _____

5. What other concomitant therapy will be used with this therapy for this diagnosis?

Renewal Requests:

Please provide clinical update on the patient's response to therapy below:

Please refer to the following page for Standard Dosing Recommendations.

Prior Authorization Form



NOTE: Refer to the Provider Manual for additional services requiring **Prior Authorization**

Fax Form To: Grand Rapids – 616 942-0024 Holland – 616 392-7626 ASO – 616 395-4090 Traverse City – 231 932-9505 Farmington Hills – 800 289-6744

Intravenous Immunoglobulin (IVIG)

Standard Dosing Recommendations

	Initial dose	Maintenance dose	Frequency	Trough target
Indication	mg/kg	mg/kg	weeks	mg/dl
Primary immunodeficiency disorders: a. X-linked agammaglobulinemia b. X-linked immunodeficiency with hyper-IgM c. Hypogammaglobulinemia d. Common variable immunodeficiency e. Combined immunodeficiency syndromes including: Wiskott-aldrich syndrome; severe combined immunodeficiency syndrome (SCIDs)	400 mg/kg	400 mg/kg	monthly	400-600 mg/dl
IgG subclass deficiency (see policy)	400 mg/kg	400 mg/kg	monthly	400-600 mg/dl
Acute idiopathic thrombocytopenia purpura (ITP)	1. 1 gm/kg body weight given on 1 or 2 consecutive days; or 2. 400 mg/kg body weight given on each of 2-5 consecutive days			
Chronic ITP	1 or 2g/kg body weight (total cumulative dose) given in equal amounts over 2-5 days	800 - 1,000 mg/kg body weight	every 2-6 weeks based on platelet counts	
Kawasaki	400 mg/kg for 4 days or a single dose of 1-2 grams/kg			
Allogenic bone marrow transplant	100-500 mg/kg		monthly	
Chronic B-cell lymphocytic leukemia (CLL)	100 – 500 mg/kg		monthly	
Pediatric HIV infection	400 mg/kg		every 28 days	
Acute & Demyelinating polyneuropathies	400 mg/kg per day for 5 days	250-400 mg/kg	2 weeks	
Post-transfusion purpura severely affected patients				
Multiple Sclerosis-relapsing-remitting type				
Fetal alloimmune thrombocytopenia				
Multiple myeloma				
Myasthenia gravis & Lambert-eaton myasthenia	400 mg/kg per day for 5 days	not covered	not covered	
Dermatomyositis & Polymyositis				
Established bacterial sepsis				
Systemic lupus erythematosus (SLE)				
Autoimmune mucocutaneous blistering diseases	up to 2 gm/kg	up to 2 gm/kg	monthly up to 6 months	