Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Medicare Part B** ☐ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Immune Globulin

Member and provider information

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. We use WPS Medicare local coverage determination L30147 (Immune Globulins) to make our decision for this drug product.

Include the following information with this request:

- ☐ Rationale for use
- ☐ Progress notes (include previous treatment failures and/or attempts to decrease the dose
- ☐ History and examination (include history of significant infections)
- ☐ Diagnostic tests (e.g. IgG, EMG, platelet count, spinal fluid tests, serum tests, biopsy findings)

Product and Billing Information

☐ J1459 – Privigen	☐ J1561 – Gamunex	☐ J1566 – Lyophilized IVIG
☐ J1569 – Gammagard Liquid	☐ J1573 – Hepagam B	☐ J2791 – Rhophylac
☐ J1559 – Hizentra	☐ J1562 – Vivaglobin	☐ J1568 – Octagam
☐ J1572 – Flebogamma/Flebogamma Dif	☐ J1599 – Non-lyophilized IVIG (liquid)	☐ Other: _____

Start date (or date of next dose): _____ **Route of administration:** ☐ intravenous ☐ subcutaneous

Date of last dose (if applicable): _____ **Patient's weight:** _____

Dose (g/kg or mg/kg): _____ **Patient's height:** _____

Dosing frequency: _____ **Trough IgG level:** _____

Duration: _____ **Date of IgG trough:** _____

Number of nursing visits (if applicable): _____ **ICD code(s):** _____

Place of administration:

- ☐ Self-administered
- ☐ Physician's office
- ☐ Outpatient infusion

  Facility: _____ NPI: _____ Fax: _____
- ☐ Home infusion

  Agency: _____ NPI: _____ Fax: _____

Billing:

- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy

  Pharmacy: _____ NPI: _____ Fax: _____

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 11/2013
Last reviewed 03/2019