

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

| | | |
|------------------------------------|----------------------|-----|
| Click on grey boxes to type | Request Date: | / / |
|------------------------------------|----------------------|-----|

| | |
|---|--|
| <input type="checkbox"/> Initial Authorization Request | <input type="checkbox"/> Subsequent Request; List Prior Auth Ref #: |
|---|--|

| |
|--|
| <input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by Crescent Healthcare (877.872.4844) |
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1. PATIENT INFORMATION

| | | | |
|-------------------------------|--------------------|-------------------------|---------------------------------------|
| Patient Last Name | Patient First Name | Anthem Member ID Number | Patient DOB / / |
| Contact Phone Number () - | Primary Diagnosis | ICD-9 Code(s) | Patient's Weight (lbs) Date: _____ |

2. PHYSICIAN INFORMATION

| | | | |
|------------------------------|----------------------------|-----------------------------|---------------------|
| Physician Last Name | Physician First Name | Physician DEA or NPI Number | Physician Tax ID |
| Address | | City | State Zip Code |
| Office Phone Number () - | Office Fax Number () - | Office Contact Name | Physician Specialty |

3. MEDICATION INFORMATION – This section serves as the active prescription – signature required.

| | | | |
|---|--|--------------------------|-------------------|
| Drug Name (please specify drug name) <input type="checkbox"/> IVIG: _____ <input type="checkbox"/> SQIG: _____ | HCPCS or CPT Code(s) <input type="checkbox"/> 90283 <input type="checkbox"/> 90284 <input type="checkbox"/> J1561 <input type="checkbox"/> J1562 <input type="checkbox"/> J1566 <input type="checkbox"/> J1568 <input type="checkbox"/> J1569 <input type="checkbox"/> J1572 <input type="checkbox"/> Q4097 | Strength / Dose | |
| Direction for Use (SIG) | | | |
| Date patient is scheduled to be treated (need by date) / / | Service From Date / / | Service Thru Date / / | Number of Refills |
| Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other: (please specify) | | | |

4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: **To avoid delays**, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended. If indicated, please provide **ALL** supporting lab results, progress notes, etc.

(1) For IVIG Use(s)

Yes No Is patient diagnosed with any of the following primary immunodeficiencies (check all that applies)?

- Hypogammaglobulinemia
- Congenital agammaglobulinemia (X-linked agammaglobulinemia)
- Common variable immunodeficiency
- X-linked immunodeficiency with hyperimmunoglobulin M
- Severe combined immunodeficiency
- Wiskott-Aldrich Syndrome

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY (continue)

For IVIG Use(s) (continue)

CONTAINS CONFIDENTIAL PATIENT INFORMATION
IV & SQ Immune Globulins (IVIG/SQIG)
PreDetermination of Medical Benefits

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- Yes No Is patient diagnosed with idiopathic thrombocytopenic purpura (ITP)?
- Yes No Is patient diagnosed with Kawasaki Syndrome?
- Yes No Is patient diagnosed with hypogammaglobulinemia and/or recurrent bacterial infection associated with B-cell chronic lymphocytic leukemia (CLL)?
- Yes No Is patient being treated for any of the following indications (check all that applies)?
- Antenatal alloimmune thrombocytopenia
 - Autoimmune neutropenia
 - Chronic inflammatory demyelinating polyneuropathy (CIDP)
 - Second-line treatment of dermatomyositis
 - Eaton-Lambert myasthenic syndrome
 - Guillian-Barre syndrome
 - Hyperimmunoglobulinemia E syndrome (HIE)
 - Multi-focal motor neuropathy in pts with anti-GM1 antibodies and conduction block
 - Severe refractory Myasthenia Gravis
 - Severe Polymyositis where other treatments have been unsuccessful
 - Suppression of panel reactive anti-HLA antibodies prior to a renal transplant
 - To prevent infections in high-risk, preterm, low birth weight neonates
 - Stiff-person syndrome not controlled by other therapies
 - Toxic shock syndrome caused by staphylococcal or streptococcal organisms
 - Solid organ transplant recipients at risk for CMV
 - Treatment of chronic parvovirus B 19 infection and severe anemia associated with bone marrow suppression
 - To reduce risk of graft-versus-host disease in pt who had an allogeneic BMT within the first 100 days after transplantation
 - To prevent infection(s) in HIV infected pediatric patients
 - Refractory auto-immune mucocutaneous blistering disease

(2) SQ Immune Globulin

- Yes No Is patient diagnosed with primary immunodeficiency?

(3) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

5. PHYSICIAN SIGNATURE

Prescriber's or Authorized Representative's Signature:

Date: ____/____/____

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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Medical Policy Reference can be found at: www.bcbsga.com

Anthem UM Services, Inc. an independent company and is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.