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

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

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:			

Specialty *(Check one):* ☐ **Oncologist** ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

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

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

E. PRODUCT INFORMATION

Request is for: ☐ **Bivigam** ☐ **Carimune NF** ☐ **Cuvitru** ☐ **Flebogamma** ☐ **GamaStan** ☐ **Gammagard** ☐ **Gammaked**
☐ **Gammaplex** ☐ **Gamunex** ☐ **Hizentra** ☐ **HyQvia** ☐ **Octagam** ☐ **Privigen**

Dose: _____ **Frequency:** _____

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)
☐ 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?
☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Is the patient medically unstable for infusions at alternate levels of care?
☐ Yes ☐ No Does the patient have a history of any cardiopulmonary conditions?
→ Please provide the description of the condition: _____
☐ Yes ☐ No Does this condition cause an increased risk of severe adverse reactions?
☐ Yes ☐ No Does the patient have documentation of unstable vascular access?
☐ Yes ☐ No Does the patient have physical or cognitive impairments such that home infusion would present an unnecessary health risk?
→ Please explain: _____
☐ Yes ☐ No Is there clinical evidence that the patient has an inability to safely tolerate intravenous volume load (including from unstable renal function)?
→ ☐ Yes ☐ No Is the inability to tolerate intravenous volume load due to unstable renal function?
→ Please document the following: ☐ GFR:____ mL/min/1.73m^2 Date Collected: ____/____/____
☐ BUN:____ mg/dL Date Collected: ____/____/____
☐ Creatinine:____ mg/dL Date Collected: ____/____/____

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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 disease
Please select which applies to the patient: ☐ Bullous pemphigoid ☐ Epidermolysis bullosa aequisita ☐ Gestational Pemphigoid ☐ Linear IgA disease ☐ Mucous membrane pemphigoid (Cicatrical pemphigoid) ☐ Pemphigus vulgaris ☐ Pemphigus folicaceus ☐ 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
☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)
☐ Dermatomyositis
☐ Yes ☐ No Will this be used as adjunctive therapy for persons who have had an inadequate response to first and second line therapies?
☐ Churg-Strauss Syndrome (CSS) (allergic granulomatosis)
☐ Yes ☐ No Will this 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 below which applies: ☐ Unsuccessful ☐ Intolerable ☐ Contraindicated
☐ 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?
☐ Yes ☐ No Does the patient have any contraindications to IVIG?
☐ 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?
Please provide current platelet count and date collected: _____ Date: ____/____/____
☐ Kawasaki Disease
☐ Lambert- Eaton myasthenic syndrome
☐ Moersch-Woltmann (Stiff-man) Syndrome
☐ Multifocal motor neuropathy
☐ 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: ***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 identify below:***
☐ Standard approaches failed ☐ Standard approaches have become intolerable ☐ Standard approaches are contraindicated
☐ Renal transplantation from live donor with ABO incompatibility or positive cross-match
☐ Yes ☐ No Are suitable non-reactive live or cadaveric donor unavailable (preparative regimen)?

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

- ☐ Secondary immunosuppression associated with major surgery
- ☐ 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 below which applies: ☐ 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
- ☐ None of the above

For Bivigam, Carimune NF, Cuvitru, GamaStan, Gammagard, Gammaked, Hizentra, Hyqvia, or Privigen Requests:

☐ Yes ☐ No Does the patient have an incomplete response to at least 3 of the following: Gammaplex, Gamunex-C, Flebogamma, or Octagam?

→ ☐ Yes ☐ No Does the patient have a documented intolerance to at least 3 of the following: Gammaplex, Gamunex-C, Flebogamma, or Octagam? If yes, please explain: _____

→ ☐ Yes ☐ No Does the patient have a documented contraindication to at least 3 of the following: Gammaplex, Gamunex-C, Flebogamma, or Octagam? If yes, please explain: _____

→ Please provide the names of the 3 medications and the date ranges of the trial:

Medication #1: _____ Date range of trial: ___/___/___ to ___/___/___

Medication #2: _____ Date range of trial: ___/___/___ to ___/___/___

Medication #3: _____ Date range of trial: ___/___/___ to ___/___/___

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.