Immunoglobulin Therapy

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval (all criteria must be met and documented in submitted chart notes):

- ❑ Medication is prescribed by or in consultation with a physician who specializes in the disease treatment.
- ❑ Documentation of FDA-approved or compendia-recommended diagnosis: _____ Chart Note Page #: _____
- ❑ Laboratory results supporting the indication for requested immune globulin, if applicable. Chart note page #: _____
- ❑ Trial and failure of guideline recommended first line treatment or the clinical rationale for the lack thereof, if appropriate. Chart note page #: _____
- ❑ Treatment plan including monitoring described in detail. Chart note page #: _____
- ❑ Use must follow FDA-approved label dosing and monitoring *(including monitoring for boxed warnings and contraindications).*
  - Applicable monitoring for boxed warnings. Chart Note Page #: _____

Non-Preferred Product: *(Criteria above must also be met)*

- ❑ Minimum 3-month trial and failure of at least one preferred product in this therapeutic class, or prescriber must demonstrate medical necessity for a non-preferred product.

  Medication(s): _____ Chart Note Page #: _____

  Dates of therapy: _____ Details of Failure: _____

Off Label Use Additional Criteria:

- ❑ Requests for any off-label indications must be supported by at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet or other peer review specialty medical journals within the most recent five (5) years. Supporting documentation must be included. Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), and the DRUGDEX Information System.
  Diagnosis: _____ Duration of treatment: _____

Re-authorization Criteria:
Updated letter of medical necessity or updated chart notes demonstrating positive clinical response

Initial Authorization: Up to six (6) months
Re-authorization: Up to twelve (12) months

Notes:

- ❖ Use appropriate HCPCS code for billing
  Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php
  Will not be approved for routine prophylaxis of rubella in early pregnancy.

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date