SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Immune Globulin Intravenous (IVIG) (immunodeficiency SQ) (Medical)

Drug Requested: Check applicable box below.

❑ **Gammagard®** [Immune Globulin Infusion (Human)] **(J1569)**	❑ **Gamunex-C®** [Immune Globulin injection (Human)] **(J1561)**
❑ **Hizentra®** [(Immune Globulin Subcutaneous (HUMAN)] **(J1559)**	❑ **Hyqvia®** [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] **(J1575)**
❑ **Cuvitru** Immune Globulin Subcutaneous (Human)] **(J1555)** (**NDCs: 0944-2850-07 / 0944-2850-05 / 0944-2850-03 / 0944-2850-01**)	

***Hyqvia®: Member must be ≥ 18 years of age**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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- **Initial Therapy Approval - 6 months**.
- **Maintenance Therapy Approval - 12 months,** for titrated doses. Doses above 1g/kg would be approved based on recent ER/hospital visits **PLUS** IVIG < 200 mg/kg **within the last 3 months.**
- **High Maintenance Approval – 3 months only.**
- ***IMPORTANT* - If recommended adjusted body weight is not accepted, a PARTIAL approval will be granted.**

Dosing should be calculated using adjusted body weight if the patient's actual body weight is 20% higher than his or her ideal body weight (IBW).

(Adjusted body weight = IBW + 0.5 (actual body weight – IBW)

- IBW (kg) for males = 50 + [2.3 (height in inches – 60)]
- IBW (kg) for females = 45.5 + [2.3 x (height in inches – 60)]

It is recommended to attempt to decrease/wean the dose for renewal requests when improvement has occurred and subsequently stop IVIG therapy if improvement is sustained with a dose reduction (this does not apply to authorizations for primary immunodeficiency as long as immunoglobulin levels are **maintained in the appropriate range).**

CLINICAL CRITERIA/DIAGNOSIS: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.	
❑ Severe combined immunodeficiency	❑ X-linked or autosomal recessive agammaglobulinemia
❑ Common variable immunodeficiency	❑ Wiskott-Aldrich syndrome
❑ CD40 ligand deficiency (X-linked hyper-IgM syndrome)	❑ Nuclear factor of κβ essential modifier deficiency
❑ Ataxia-telangiectasia	❑ DiGeorge Syndrome

- ❑ Member's IgG level <200 mg/dL **OR** both of the following:
  - ❑ Member has a history of multiple hard to treat infections as indicated by at least **ONE** of the following:
    - ❑ Four or more ear infections within 1 year
    - ❑ Two or more serious sinus infections within 1 year
    - ❑ Two or more months of antibiotics with little effect
    - ❑ Two or more pneumonias within 1 year
    - ❑ Recurrent or deep skin abscesses
    - ❑ Need for intravenous antibiotics to clear infections
    - ❑ Two or more deep-seated infections including septicemia

AND

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- ❑ Member has a deficiency in producing antibodies in response to vaccination;

AND

- ❑ Titers were drawn before challenging with vaccination;

AND

- ❑ Titers were drawn between 4 and 8 weeks of vaccination

Continuation of Therapy Approval - 12 months, if titrates considered by MagellanRx

- ❑ Disease response as evidenced by one or more of the following:
  - ❑ Decrease in the frequency of infection
  - ❑ Decrease in the severity of infection

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____
- ❑ **NPI or DEA # of administering location:** _____

OR

- ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****