



Immunoglobulins Therapy Medication and/or Infusion Precertification Request

Page 1 of 6

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

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: Asceniv Bivigam Carimune NF Cutaquig Cuvitru Flebogamma DIF Hizentra HyQvia GamaSTAN
 GamaSTAN S/D Gammagard Liquid Gammagard S/D Gammaked Gammaplex Gamunex-C Octagam
 Panzyga Privigen Xembify

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.

For All Requests (EXCEPT GamaSTAN and GamaSTAN S/D, refer to page six for GamaSTAN and GamaSTAN requests) (clinical documentation required for all requests):

Yes No Has the patient received immunoglobulin therapy for a requested indication within the last 3 months?

Yes No Is this infusion request in an outpatient hospital setting?

Yes No Is this request to continue previously established treatment with the requested medication?

 Please explain: This is a new therapy request (patient has not received requested medication in the last 6 months)
 This is a request for a different brand immune globulin product that the patient has not received previously

 Please select the continuation request:
 This is a continuation of an existing treatment
 This is a continuation request, however a gap in therapy of greater than 8 weeks has occurred

Yes No Does the patient have laboratory confirmed autoantibodies to immunoglobulin A?

Yes No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

Yes No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

Yes No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

 Please provide a description of the behavioral issue or impairment: _____

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

Yes No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition:

Cardiovascular: _____

Respiratory: _____

Renal: _____

For Initiation requests (EXCEPT GamaSTAN and GamaSTAN S/D, refer to page six for GamaSTAN and GamaSTAN requests) (clinical documentation required for all requests):

Acquired red cell aplasia

Acute disseminated encephalomyelitis

Yes No Has the patient had an insufficient response or contraindication to intravenous corticosteroid treatment?

Autoimmune hemolytic anemia

Which type of autoimmune hemolytic anemia does the patient have? warm type cold type other

Yes No Has the patient tried corticosteroids with inadequate response?

→ Yes No Has the patient had a splenectomy with inadequate response?

→ Yes No Does the patient have a contraindication to corticosteroids or splenectomy?

Autoimmune mucocutaneous blistering diseases

Please select which applies to the patient: Bullous pemphigoid Epidermolysis bullosa acquisita Pemphigus vulgaris

Mucous membrane pemphigoid Pemphigus foliaceus

Other, please explain: _____

Yes No Has the diagnosis been proven by biopsy and confirmed by pathology report?

Yes No Is the condition rapidly progressing, extensive, or debilitating?

Yes No Has the patient failed or experienced significant complications (e.g., diabetes, steroid-induced osteoporosis) from standard treatment (corticosteroids, immunosuppressive agents)?

Autoimmune neutropenia

Yes No Is treatment with G-CSF (granulocyte colony stimulating factor) an appropriate option? Examples of G-CSF include Fulphila, Granix, Leukine, Neulasta, Neupogen, Udenyca, Zarxio.

B-cell chronic lymphocytic leukemia (CLL)

Please provide the patient's pre-treatment IgG level: _____

Yes No Is IG prescribed for prophylaxis of bacterial infections?

Yes No Does the patient have a history of recurrent sinopulmonary infections requiring intravenous antibiotics or hospitalization?

Birdshot retinochoroidopathy

Yes No Has the patient tried immunosuppressant therapy (e.g., corticosteroids, cyclosporine) with inadequate response?

BK virus associated nephropathy

Bone marrow transplant/hematopoietic stem cell transplant recipient

Yes No Is IG prescribed for prophylaxis of bacterial infections?

Yes No Has the patient received a bone marrow/hematopoietic stem cell transplant within the past 100 days?

→ Please provide the patient's pre-treatment IgG level: _____

CAR-T therapy related hypogammaglobulinemia

Please provide the patient's IgG level: _____

Yes No Has the patient received treatment with CAR-T therapy (including but not limited to: idecabtagene vicleucel [Abecma], tisagenlecleucel [Kymriah] or axicabtagene ciloleucel [Yescarta])?

Chronic inflammatory demyelinating polyneuropathy (CIPD)

Yes No Is the disease course progressive or relapsing/remitting for 2 months or longer?

Yes No Does the patient have moderate to severe functional disability?

Yes No Were electrodiagnostic studies (electromyography [EMG] or nerve conduction studies [NCS]) and the evaluation of cerebrospinal fluid (when available) performed to confirm the diagnosis?

Churg-Strauss Syndrome

Yes No Does the patient have severe, active disease?

Yes No Will immune globulin be used as adjunctive therapy?

Yes No Has the patient experienced failure, intolerance, or is contraindicated to other interventions?

Dermatomyositis OR Polymyositis

Please select clinical features the patient exhibits (select all that apply): Proximal muscle weakness (upper or lower extremity and trunk)

Elevated serum creatine kinase (CK) or aldolase level Muscle pain on grasping or spontaneous pain Non-destructive arthritis or arthralgias

Myogenic changes on EMG (short-duration, polyphasic motor unit potentials with spontaneous fibrillation potentials)

Positive for anti-synthetase antibodies (e.g., anti-Jo-1, also called histidyl tRNA synthetase)

Systemic inflammatory signs (fever: more than 37°C at axilla, elevated serum CRP level or accelerated ESR of more than 20 mm/h by the Westergren method)

Pathological findings compatible with inflammatory myositis (inflammatory infiltration of skeletal evidence of active regeneration may be seen)

The patient does not exhibit clinical features

Yes No Were electrodiagnostic studies (electromyography [EMG] and the muscle biopsy (when available) performed to confirm the diagnosis?

Yes No Were standard first-line (corticosteroids) and second-line (immunosuppressants) treatments tried but were unsuccessful or not tolerated?

→ Yes No Is the patient unable to receive standard first-line and second-line therapy because of a contraindication or other clinical reason?

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Enteroviral meningoencephalitis
 Yes No Is the patient's condition severe?

Guillain-Barre Syndrome (GBS)
 Yes No Does the patient have severe disease with significant weakness (e.g., inability to stand or walk without aid, respiratory weakness)?
 Yes No Did the onset of neurologic symptoms occur less than 4 weeks from the anticipated start of immunoglobulin therapy?

Hemophagocytic lymphohistiocytosis (HLH) OR Macrophage activation syndrome (MAS)
Please provide the patient's total IgG level: _____ (Please provide a copy of the laboratory report with the pre-treatment IgG level)
 Yes No Is the patient's total IgG level less than 400mg/dL?
 Yes No Is the IgG level two standard deviations below the mean for age?

Human immunodeficiency virus (HIV) infection
For a **pediatric** patient:
 Yes No Is the requested drug being prescribed for prophylaxis of bacterial infections?
 Yes No Is the requested drug being prescribed for treatment of thrombocytopenia associated with HIV?
Please provide the patient's pre-treatment IgG level: _____
 Yes No Has the patient had 2 or more bacterial infections in a 1-year period despite antibiotic chemoprophylaxis with TMP-SMZ or another active agent?
 Yes No Does the patient have HIV-associated thrombocytopenia despite anti-retroviral therapy?
Please provide the patient's T4 cell count: _____
For T4 cell count less than 200/mm³ or unknown:
 Yes No Does the patient live in an area where measles is highly prevalent?
 Yes No Has the patient failed to develop an antibody response after two doses of measles, mumps, and rubella live virus vaccine?
 Yes No Does the patient have chronic bronchiectasis that is suboptimally responsive to antimicrobial and pulmonary therapy?
Please indicate whether IG will be used for primary or secondary prophylaxis:
 primary prophylaxis
 secondary prophylaxis
Please provide the patient's pre-treatment IgG level: _____
 Yes No Does the patient have a history of recurrent bacterial infections (>2 serious bacterial infections in a 1-year period)?
 other prophylaxis
 Yes No Has the patient failed to form antibodies to common antigens, such as measles, pneumococcal, and/or Haemophilus influenzae type b vaccine?
 Yes No Is this request for a single dose of immune globulin for a patient who has been exposed to measles?
 Yes No Does the patient live in an area where measles is highly prevalent?
 Yes No Has the patient failed to develop an antibody response after two doses of measles, mumps, and rubella live virus vaccine?
 Yes No Does the patient have chronic bronchiectasis that is suboptimally responsive to antimicrobial and pulmonary therapy?

For an **adult** patient:
 Yes No Is the requested drug being prescribed for treatment of thrombocytopenia associated with HIV?
 Yes No Does the patient have significant bleeding?
Please provide the patient's platelet count: _____ /mCL
 Yes No Is the patient Rh-positive?
 Yes No Has the patient failed treatment with RhIG?

Hyperimmunoglobulinemia E Syndrome
 Yes No Does the patient have severe eczema?

Immune thrombocytopenic purpura (ITP)
 Yes No Is the patient a pregnant woman? If yes, please provide estimated date of delivery: ____/____/____
Please select which of the following applies to the patient:
 The patient is an adult with refractory ITP after splenectomy:
Please select the current pretreatment platelet count:
 Less than 30,000/mcL (30 x 10⁹/L)
 Greater than 30,000/mcL (30 x 10⁹/L)
 Yes No Does the patient have significant bleeding symptoms (e.g., mucosal bleeding or other moderate to severe bleeding)?

For Newly diagnosed, previously treated, chronic or persistent or ITP unresponsive to first line treatment:
 Yes No Does the patient have significant bleeding symptoms (e.g., mucosal bleeding or other moderate to severe bleeding)?
 Yes No Is the patient at high risk for bleeding or does the patient require a rapid increase in platelets?
Please indicate the risk factors:
 Comorbidity (e.g., peptic ulcer disease or hypertension)
 Undergoing a medical or dental procedure where blood loss is anticipated
 Mandated anticoagulation therapy
 Profession or lifestyle predisposes the patient to trauma (e.g., construction worker, fireman, professional athlete)
 Other, please explain: _____

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

Newly diagnosed ITP (diagnosed within the past 3 months) OR Previously untreated ITP (initial therapy)

newly diagnosed children

newly diagnosed adults:

→ Please indicate the patient's current pretreatment platelet count:

Less than 30,000/mcL ($30 \times 10^9/L$)

→ Please select the prescribed regimen:

IG monotherapy

→ Yes No Is corticosteroid therapy contraindicated?

IG in combination with corticosteroid

Other

30,000 to less than 100,000/mcL (30×10^9 to $< 100 \times 10^9/L$)

Greater than or equal to 100,000/mcL ($100 \times 10^9/L$)

Chronic or persistent ITP (≥ 3 months from diagnosis) OR ITP unresponsive to first-line treatment:

Please indicate the current pretreatment platelet count:

Less than 30,000/mcL ($30 \times 10^9/L$)

→ Yes No Does the patient have relapsed ITP after a previous response to IG therapy?

Yes No Does the patient have a history of inadequate response, intolerance or a contraindication to corticosteroid or anti-D therapy?

30,000 to less than 100,000/mcL (30×10^9 to $< 100 \times 10^9/L$)

Greater than or equal to 100,000/mcL ($100 \times 10^9/L$)

Other classification of ITP

Immune checkpoint inhibitor related toxicity

Yes No Has the patient experienced a moderate or severe adverse event to a PD-1 inhibitor (e.g., pembrolizumab, nivolumab) or PD-L1 inhibitor (e.g., atezolizumab, avelumab, durvalumab)?

Yes No Is the offending drug being temporarily held or has it been discontinued permanently?

Please select which of the following adverse events the patient experienced: pneumonitis myasthenia gravis peripheral neuropathy

encephalitis transverse myelitis severe inflammatory arthritis other

Isoimmune hemolytic disease of newborn

Kawasaki syndrome (pediatric)

Lambert-Eaton myasthenic syndrome

Yes No Has the diagnosis been confirmed by neurophysiology studies (e.g., electromyography) or a positive anti- P/Q type voltage-gated calcium channel antibody test?

→ Please select: neurophysiology studies positive anti- P/Q type voltage-gated calcium channel antibody test

Yes No Has the patient tried an anticholinesterase (e.g., pyridostigmine) but it was unsuccessful or not tolerated?

Yes No Has the patient tried amifampridine (e.g., 3,4-diaminopyridine phosphate, Firdapse) but it was unsuccessful or not tolerated?

Yes No Does the patient have severe weakness?

→ Yes No Is there difficulty with venous access for plasmapheresis?

Multifocal motor neuropathy

Yes No Has the patient experienced progressive, multifocal, asymmetrical weakness without objective sensory loss in 2 or more nerves for at least 1 month?

Yes No Were electrodiagnostic studies (electromyography [EMG] or nerve conduction studies [NCS]) performed to confirm the diagnosis?

Multiple Myeloma

Yes No Does the patient have recurrent, serious infections despite the use of prophylactic antibiotics?

Myasthenia Gravis

Please indicate the primary reason for IG is being prescribed:

Refractory myasthenia gravis

→ Yes No Has the patient tried and failed 2 or more standard therapies (e.g., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, rituximab)?

Acute exacerbation/crisis

→ Yes No Does the patient have severe swallowing difficulty and/or respiratory failure?

→ Yes No Does the patient have weakness with an increase in any of the following symptoms: diplopia, ptosis, blurred vision, difficulty speaking (dysarthria), difficulty swallowing (dysphagia), difficulty chewing, impaired respiratory status, fatigue, or limb weakness?

Worsening weakness

→ Yes No Does the patient have weakness with an increase in any of the following symptoms: diplopia, ptosis, blurred vision, difficulty speaking (dysarthria), difficulty swallowing (dysphagia), difficulty chewing, impaired respiratory status, fatigue, or limb weakness?

Pre-operative management (e.g., prior to thymectomy)

Other, please explain: _____

Neonatal Alloimmune Thrombocytopenia (NAIT) (also known as Fetal Alloimmune Thrombocytopenia or FAIT)

Neonatal Hemochromatosis

Yes No Is the patient currently pregnant?

→ Yes No Does the patient have a history of pregnancy ending in documented neonatal hemochromatosis?

Opsoclonus-myoelonus

Yes No Does the patient have paraneoplastic opsoclonus-myoelonus-ataxia associated with neuroblastoma?

→ Yes No Does the patient have refractory opsoclonus-myoelonus?

Yes No Is immune globulin being used as last-resort treatment?

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

- Parvovirus B19-induced pure red cell aplasia (PRCA)**
 - Yes No Does the patient have severe, refractory anemia associated with bone marrow suppression?
 - Yes No Does the patient have parvovirus B19 viremia?
- Post-transfusion purpura**
- Primary immunodeficiency (e.g., common variable immunodeficiency, X-linked agammaglobulinemia, severe combined immunodeficiency, Wiskott-Aldrich syndrome)**
 - Yes No Does the patient have a history of recurrent bacterial infections (e.g., pneumonia, otitis media, sinusitis, sepsis, gastrointestinal infections)?
 - Yes No Was the immune globulin therapy initiated in the hospital setting?
 - For the patient of 2 years of age or older:
 - Yes No Has the patient demonstrated an impaired antibody response to vaccination with a pneumococcal polysaccharide vaccine?
 - Please indicate the specific immunodeficiency disorder:
 - Common variable immunodeficiency (CVID)
 - Yes No Have other causes of immune deficiency been excluded (e.g., drugs, infectious disease, malignancy)?
 - Please provide the patient's pre-treatment IgG level: _____
 - For pre-treatment IgG level greater than or equal to 500 mg/dL:
 - Yes No Is the patient's pretreatment IgG level \geq 2 SD below the mean for age?
 - Hypogammaglobulinemia (unspecified) or other predominant antibody deficiency disorder
 - Please provide the patient's pre-treatment IgG level: _____
 - For pre-treatment IgG level greater than or equal to 500 mg/dL:
 - Yes No Is the patient's pretreatment IgG level \geq 2 SD below the mean for age?
 - IgG subclass deficiency
 - Yes No Does the patient have low levels of any IgG subclasses?
 - Please select the subclass: IgG1 IgG2 IgG3 Other
 - Yes No Was the IgG subclass level \geq 2 SD below the mean for age measured on at least 2 different occasions?
 - Yes No Does the patient have normal pre-treatment total IgG levels, normal IgM levels and normal/low IgA levels?
 - Selective IgA deficiency
 - Please indicate the patient's pre-treatment IgA level: _____
 - Yes No Does the patient have normal pre-treatment IgG and IgM levels?
 - Selective IgM deficiency
 - Please indicate the patient's pre-treatment IgM level: _____
 - Yes No Does the patient have normal pre-treatment IgG and IgA levels?
 - Severe combined immunodeficiency (SCID)
 - Yes No Was the diagnosis confirmed by molecular or genetic testing?
 - Please indicate the patient's pre-treatment IgG level: _____
 - For pre-treatment IgG greater than or equal to 200 mg/dL:
 - Yes No Are maternal T-cells present in the circulation?
 - Please indicate the patient's CD3 T-cell count: _____
 - Other non-SCID combined immunodeficiency disorder
 - Yes No Was the diagnosis confirmed by molecular or genetic testing?
 - Congenital agammaglobulinemia (e.g., X-linked or autosomal recessive agammaglobulinemia)
 - Yes No Was the diagnosis confirmed by molecular or genetic testing?
 - Please indicate the patient's pre-treatment IgG level: _____
 - Specific antibody deficiency
 - Yes No Does the patient have normal pre-treatment IgG, IgA, and IgM levels?
 - Other immunodeficiency disorder/none of the above
- Rasmussen encephalitis**
 - Yes No Did the patient try anti-epileptic drugs with no improvement in symptoms?
 - Yes No Did the patient try corticosteroids with no improvement in symptoms?
- Secondary Immunosuppression Due to Surgery, Malignancy, Burns, Collagen-Vascular Diseases**

Please select which of the following applies to the patient:

 - Major surgery associated secondary immunosuppression Hematologic malignancy associated secondary immunosuppression
 - Major burns associated secondary immunosuppression Collagen-vascular disease associated secondary immunosuppression

Please indicate the patient's pre-treatment IgG level: _____

 - Yes No Is immune globulin being requested to prevent or modify recurrent bacterial or viral infections?
- Solid organ transplantation**
 - Yes No Is immune globulin being prescribed for solid organ transplantation in an allosensitized patient?
 - Yes No Is the patient undergoing renal transplantation from a live donor with ABO incompatibility or positive cross match?
- Stiff person syndrome**
 - Yes No Has the diagnosis been confirmed by anti-glutamic acid decarboxylase (GAD) antibody testing?
 - Yes No Has the patient received first-line treatment with benzodiazepines and/or baclofen and experienced an inadequate response?
- Systemic lupus erythematosus (SLE)**
 - Yes No Does the patient have severe, active disease?
 - Yes No Has the patient experienced inadequate response, intolerance, or have a contraindication to first line therapy?
 - Yes No Has the patient experienced inadequate response, intolerance, or have a contraindication to second line therapy?

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Toxic epidermal necrolysis OR Steven-Johnson Syndrome

Yes No Is the patient's case severe?

Toxic necrotizing fasciitis

Yes No Does the patient have toxic necrotizing fasciitis due to invasive group A streptococcal infection?

Toxic shock syndrome

Yes No Does the patient have toxic shock syndrome due to a staphylococcal or streptococcal infection?

Yes No Is the infection refractory to several hours of aggressive therapy?

Yes No Does the patient have an undrainable focus of infection?

Yes No Does the patient have persistent oliguria with pulmonary edema?

For GamaSTAN and GamaSTAN S/D ONLY (clinical documentation required for all requests):

Prophylaxis of hepatitis A

Yes No Was the patient exposed to hepatitis A virus within the past 2 weeks (e.g., household contact, sexual contact, childcare center or classroom contact with an infected person)?

Yes No Is the patient exhibiting clinical manifestation of disease?

Yes No Is the patient at high risk for exposure to hepatitis A virus (examples of populations at high risk for hepatitis A are travelers to and workers in countries of high endemicity of infection and illicit drug users)?

Prophylaxis of measles (rubeola)

Yes No Was the patient exposed to measles within the past 6 days?

Yes No Has the patient ever received the measles vaccine (e.g., MMR)?

Yes No Has the patient ever had the measles?

Prophylaxis of rubella

Yes No Was the patient recently exposed to rubella?

Yes No Is the patient currently pregnant?

Prophylaxis of varicella (chickenpox)

Yes No Was the patient exposed to varicella within the past 10 days?

Yes No Is the patient at high risk for severe varicella (e.g., immunocompromised, newborn/infant, pregnant woman)?

Yes No Is varicella zoster immune globulin (e.g., Varizig) currently not available?

For Continuation Requests (Exception GamaSTAN and GamaSTAN S/D ONLY) (clinical documentation required for all requests):

B-cell chronic lymphocytic leukemia (CLL) OR Bone marrow transplant/hematopoietic stem cell transplant recipient OR

Human immunodeficiency virus (HIV) infection (prophylaxis or thrombocytopenia)

Yes No Has the patient experienced a reduction in the frequency of bacterial infections since starting IG therapy?

Chronic inflammatory demyelinating polyneuropathy (CIDP)

Yes No Has the patient demonstrated significant improvement in disability and maintenance of improvement since starting IG therapy?

Yes No Is IG being used at the lowest effective dose and frequency?

Dermatomyositis OR Polymyositis

Yes No Has the patient demonstrated significant improvement in disability and/or maintenance of improvement since starting IG therapy?

Lambert-Eaton myasthenic syndrome

Yes No Has the patient experienced stability or improvement in symptoms relative to the natural course of LEMS?

Multifocal motor neuropathy

Yes No Has the patient demonstrated significant improvement in disability and/or maintenance of improvement since starting IG therapy?

Primary immunodeficiency (e.g., common variable immunodeficiency, X-linked agammaglobulinemia, severe combined immunodeficiency, Wiskott-Aldrich syndrome)

Yes No Has the patient experienced a reduction in the frequency of bacterial infections since starting immune globulin therapy?

Yes No Does the prescriber measure trough IgG levels at least once per year?

Yes No Is the measure trough IgG level applicable for diagnosis?

Yes No Is the most recent trough IgG level at or above the lower range of normal for age?

Yes No Is this value applicable for diagnosis?

Yes No Will the prescriber re-evaluate the dose of immune globulin and consider a dose adjustment (when clinically appropriate)?

Yes No Is this applicable/not clinically appropriate?

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.