



2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Immune Globulin: Intravenous (IVIG) - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, and Specialty/facility name.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields for Drug Name, Strength, and Directions / SIG.

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.

Five question sections (Q1-Q5) regarding therapy continuation, clinical response, specialist consultation, product type, and Medicare coverage.



2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Immune Globulin: Intravenous (IVIG) - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

Q6. Does the patient have the diagnosis of autoimmune mucocutaneous blistering disease (e.g., pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane [cicatricial] pemphigoid, benign mucous membrane pemphigoid, epidermolysis bullosa acquisita)? Must attach documentation.

Yes

No

Q7. Does the patient meet one of the following: A) inadequate response or inability to tolerate conventional therapy (i.e., steroids, immunosuppressants) OR B) rapidly progressive disease in conjunction with conventional therapy (i.e., steroids, immunosuppressants)? Must attach documentation.

Yes

No

Q8. Does a patient have erythema multiforme major (SJS, TEN) and SCORTEN level 3 or greater? Must attach documentation.

Yes

No

Q9. Does the patient have the diagnosis of scleromyxedema? Must attach documentation.

Yes

No

Q10. Does the patient have the diagnosis of acute idiopathic thrombocytopenia purpura (ITP)? Must attach documentation.

Yes

No

Q11. Does the patient require or have ONE of the following: A) management of acute bleeding, B) need to increase platelet count prior to surgical procedures, C) severe thrombocytopenia (platelets less than 20,000 per microliter), or D) high risk for intracerebral hemorrhage? Must attach documentation.

Yes

No

Q12. Does the patient have a diagnosis of chronic ITP? Must attach documentation.

Yes

No

Q13. Does the patient have ALL of the following: (a) inadequate response or inability to tolerate corticosteroids, (b) duration of illness greater than 6 months, and (c) platelets persistently less than 20,000 per uL? Must attach documentation.

Yes

No



2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Immune Globulin: Intravenous (IVIG) - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
Q14. Does the patient have chronic B-cell lymphocytic leukemia with IgG less than 600 mg/dL and recurrent, serious bacterial infections requiring antibiotic therapy? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q15. Does the patient have a diagnosis of hematopoietic stem cell transplant and IgG less than 400 mg/dL? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q16. Does the patient have a diagnosis of HIV? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q17. Does the patient meet all of the following: A) less than 14 years of age, B) evidence of qualitative or quantitative humoral immunologic defects and C) current bacterial infection despite antimicrobial prophylaxis? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q18. Has the member had a solid organ transplant? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q19. Does the patient have the diagnosis of chronic inflammatory demyelinating polyneuritis confirmed by electrodiagnostic testing or nerve biopsy and an inadequate response or inability to tolerate corticosteroids? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q20. Does the patient have a diagnosis of dermatomyositis or polymyositis diagnosed by laboratory testing (antinuclear or myositis specific antibodies, biopsy, EMG, or MRI) AND inadequate response or inability to tolerate steroids OR immunosuppressants? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q21. Does the patient have the diagnosis of Guillain-Barre syndrome with impaired function (i.e., unable to stand or walk without aid)? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	



2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Immune Globulin: Intravenous (IVIG) - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
Q22. Does the patient have the diagnosis of Lambert Eaton myasthenic syndrome (LEMS) refractory to steroids, immunosuppressants, or cholinesterase inhibitors? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q23. Does the patient have multifocal motor neuropathy diagnosed by electrodiagnostic studies? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q24. Does the patient experience acute exacerbations of multiple sclerosis unresponsive to steroids? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q25. Does the patient have the diagnosis of myasthenia gravis that is refractory to at least 8 weeks of standard therapy (steroids, immunosuppressants, cholinesterase inhibitors)? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q26. Is the patient experiencing myasthenic crisis? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q27. Does the patient have the diagnosis of stiff person syndrome refractory to standard therapy (muscle relaxants, benzodiazepines, gabapentin)? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q28. Does the patient have a diagnosis of severe, active SLE unresponsive to steroids? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q29. Does the patient have the diagnosis of Kawasaki disease? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q30. Requested Duration: <input type="checkbox"/> 3 Months	
Q31. Additional Information:	



2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Immune Globulin: Intravenous (IVIG) - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:

Prescriber Signature

Date

2024 Medicare Prior Authorization Request