



**MEDICARE ADVANTAGE
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.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

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.

Drug Name:	
Strength:	
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.**

Q1. Is this a request for a continuation of therapy with intravenous immune globulin? If YES, go to 2. If NO, go to 3.

Yes No

Q2. Has the patient demonstrated clinical response to therapy based on an objective clinical measuring tool appropriate to the diagnosis (such as INCAT, Medical Research Council (MRC) muscle strength, 6-MWT, Rankin, Modified Rankin, Activities of Daily Living (ADL) scores)? Must attach documentation.

Yes No

Q3. Is the requested product being prescribed by or in consultation with a specialist (allergist, immunologist, hematologist, cardiologist, oncologist, or neurologist)? If YES, go to 4.

Yes No

Q4. Is the request for one of the following products: Bivigam, Flebogamma, Gammagard Liquid, Gammagard S/D, Gammagard ERC, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, or Privigen? If YES, go to 5.

Yes No



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Member Name:	Prescriber Name:
Q5. Is the medication covered under Medicare Part B? If NO, go to 6. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Does the patient have a diagnosis of autoimmune mucocutaneous blistering disease pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane (cicatrical) pemphigod, benign mucous membrane pemphigoid, epidermolysis bullosa acquisita? Must attach documentation. If YES, go to 7. If NO, go to 8. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Does the patient have one of the following: (a) documentation of inadequate response, intolerance, or contraindication to one conventional therapy (ie steroid, immunosuppressant) OR (b) rapidly progressive disease in conjunction with one conventional therapy (such as steroid, immunosuppressant)? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Does a patient have erythema multiforme major (SJS, TEN) and SCORTEN level 3 or greater? Must attach documentation. If NO, go to 9. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Does the patient have a diagnosis of acute idiopathic thrombocytopenia purpura (ITP)? Must attach documentation. If YES, go to 10. If NO, go to 11. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. 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 uL); OR D. High risk for intracerebral hemorrhage? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Does the patient have a diagnosis of chronic ITP? Must attach documentation. If YES, go to 12. If NO, go to 13. <input type="checkbox"/> Yes <input type="checkbox"/> No	



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Member Name:	Prescriber Name:
Q12. Does the patient have ALL of the following: (a) documentation of inadequate response, intolerance, or contraindication to one steroid, (b) duration of illness greater than 6 months, and (c) platelets persistently less than 20,000 per uL? Must attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. 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. If NO, go to 14. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q14. Does the patient have a diagnosis of hematopoietic stem cell transplant and IgG less than 400 mg/dL? Must attach documentation. If NO, go to 15. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q15. Does the patient have a diagnosis of HIV? Must attach documentation. If YES, go to 16. If NO, go to 17. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q16. Does the patient have 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	
Q17. Has the member had a solid organ transplant? Must attach documentation. If NO, go to 18. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q18. Does the patient have a diagnosis of chronic inflammatory demyelinating polyneuritis confirmed by electrodiagnostic testing or nerve biopsy and documentation of inadequate response, intolerance, or contraindication to one steroid? Must attach documentation. If NO, go to 19. <input type="checkbox"/> Yes <input type="checkbox"/> No	



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Member Name:	Prescriber Name:
Q19. Does the patient have a diagnosis of dermatomyositis or polymyositis diagnosed by laboratory testing (antinuclear or myositis specific antibodies, biopsy, EMG, or MRI) AND documentation of inadequate response, intolerance, or contraindication to one steroid OR immunosuppressant? Must attach documentation. If NO, go to 20.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Does the patient have a diagnosis of Guillain Barre syndrome with impaired function (i.e. unable to stand or walk without aid)? Must attach documentation. If NO, go to 21.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q21. Does the patient have Lambert Eaton myasthenic syndrome refractory to one of the following: steroid, immunosuppressant, or cholinesterase inhibitor? Must attach documentation. If NO, go to 22.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q22. Does the patient have multifocal motor neuropathy diagnosed by electrodiagnostic studies? Must attach documentation. If NO, go to 23.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q23. Does the patient experience acute exacerbations of multiple sclerosis unresponsive to one steroid? Must attach documentation. If NO, go to 24.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q24. Does the patient have a diagnosis of myasthenia gravis that is refractory to 8 weeks of one standard therapy (steroid, immunosuppressant, cholinesterase inhibitor)? Must attach documentation. If NO, go to 25.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q25. Is the patient experiencing myasthenic crisis? Must attach documentation. If NO, go to 26.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No



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Q26. Does the patient have a diagnosis of stiff person syndrome refractory to one standard therapy (muscle relaxant, benzodiazepine, gabapentin)? Must attach documentation. If NO, go to 27.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q27. Does the patient have a diagnosis of severe, active SLE unresponsive to one steroid? Must attach documentation. If NO, go to 28.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q28. Does the patient have a diagnosis of Kawasaki disease? Must attach documentation.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q29. For Renewal: Has the patient demonstrated clinical response to therapy based on an objective clinical measuring tool appropriate to the diagnosis (such as INCAT, Medical Research Council (MRC) muscle strength, 6-MWT, Rankin, Modified Rankin, Activities of Daily Living (ADL) scores)? Must attach documentation.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q30. Requested Duration:	
<input type="checkbox"/> 6 Months	
Q31. Additional Information:	

Prescriber Signature

Date

v2026