



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form - IVIG (Intravenous Immune Globulin)-

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes <input type="checkbox"/> No <input type="checkbox"/>			* Patient Street Address:		
* May we fax our response to your office? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		
Medication requested:					
<input type="checkbox"/> Gamimune N	<input type="checkbox"/> Gammar	<input type="checkbox"/> Polygam S/D	<input type="checkbox"/> Gammagard S/D	<input type="checkbox"/> Gammagard Liquid	
<input type="checkbox"/> Carimune	<input type="checkbox"/> Carimune NF	<input type="checkbox"/> Panglobulin NF	<input type="checkbox"/> Venoglobulin-S	<input type="checkbox"/> Immune Globulin, Gamma	
<input type="checkbox"/> Baygam	<input type="checkbox"/> Flebogamma	<input type="checkbox"/> Iveegam EN	<input type="checkbox"/> Other (Please specify):		
Dose requested:		Dose (mg/kg):	JCode:		
Frequency of administration:		Duration of therapy:	Patient's current weight:		
Place of service:					
<input type="checkbox"/> Provider's office					
<input type="checkbox"/> Patient's home (please specify Home Health / Home Infusion vendor):					
<input type="checkbox"/> Infusion center (please specify name):					
<input type="checkbox"/> Other (please specify):					
Please specify the following:					
Has this patient been treated with IVIG in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<i>If Yes, please complete reauthorization criteria in addition to the diagnosis specific criteria on this form.</i>					
1. Primary Immunodeficiency					
<input type="checkbox"/>	Congenital / X-linked agammaglobulinemia-(XLA) Bruton's Disease				
<input type="checkbox"/>	Autosomal recessive agammaglobulinemia – (ARA)				
<input type="checkbox"/>	Autosomal recessive hyper-IgM syndrome (HIM)				
<input type="checkbox"/>	Congenital Hypogammaglobulinemia				
<input type="checkbox"/>	ICF Syndrome				
<input type="checkbox"/>	Common variable immunodeficiency (CVID)				
<input type="checkbox"/>	Selective IgA Deficiency				

<input type="checkbox"/>	Selective IgG subclass deficiencies (IGGSD)
<input type="checkbox"/>	Specific Antibody Deficiency (SAD)
<input type="checkbox"/>	Transient hypogammaglobulinemia of infancy
<input type="checkbox"/>	Hypogammaglobulinemia, unspecified
<input type="checkbox"/>	Severe combined immunodeficiency disorder (SCID)
<input type="checkbox"/>	Wiskott Aldrich syndrome (WAS)
<input type="checkbox"/>	Ataxia-telangiectasia (A-T) including (NBS)
<input type="checkbox"/>	DiGeorge syndrome (DGS)
<input type="checkbox"/>	Hyper-IgM syndrome
<input type="checkbox"/>	X-linked lymphoproliferative syndrome
<input type="checkbox"/>	(WHIM) warts, hypogammaglobulinemia, immunodeficiency, and myelokathexis
<input type="checkbox"/>	Defects of NF-κB regulation Defects of Toll-like receptor signaling
<input type="checkbox"/>	Other (please specify):
Pre Treatment Immunoglobulin levels <i>copies of lab reports required, including:</i> Total immunoglobulin levels: Ig G subclasses (if applicable): B cells (if applicable): Genetic testing confirming the diagnosis (if applicable):	
Vaccine response results <i>copies of lab reports required, including</i> pre & post vaccination responses for pneumococcal, diphtheria, tetanus vaccines	
Details of recurrent infections <i>copies of clinical records required that address the following:</i> Sites of infections: When did the infections start? How many episodes per year? How many courses of antibiotics per year? List of the names of antibiotics and durations: Are underlying conditions such as asthma, allergic rhinitis under control? <input type="checkbox"/> Yes <input type="checkbox"/> No Supporting diagnostic imaging or lab results of recurrent infections where applicable:	
For reauthorization requests <i>copies of clinical records required, including:</i> Trough Ig G levels: Response to IVIG:	
2. Secondary Immunodeficiency	
<input type="checkbox"/>	High-risk, preterm, low-birth-weight neonates
<input type="checkbox"/>	Multiple Myeloma <i>copies of clinical records and lab reports required:</i> Has the disease been stable for 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Pre treatment Ig G level: Number of recurrent sino pulmonary infections per year:
<input type="checkbox"/>	CLL <i>copies of clinical records and lab reports required:</i> Pre treatment Ig G level:

	Number of recurrent sino pulmonary infections per year:
<input type="checkbox"/>	Allogeneic hematopoietic stem cell transplant (HSCT) <i>copies of clinical records and lab reports required:</i> Date of transplant: Pre treatment Ig G levels: Number of recurrent sino pulmonary infections per year:
<input type="checkbox"/>	Allosensitized solid organ transplants
<input type="checkbox"/>	Bone marrow transplantation Date of transplant:
<input type="checkbox"/>	HIV CD 4 counts: Current antiretroviral medications:
3. Hematology	
<input type="checkbox"/>	Acute Idiopathic Thrombocytopenic Purpura (ITP) Is there active bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No What is the platelet count? _____ Date: _____ Are there any major surgical procedures planned? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Date: _____
<input type="checkbox"/>	Chronic Idiopathic Thrombocytopenic Purpura (ITP) <i>copies of clinical records and lab reports required:</i> What is the duration of ITP? Are there any other concurrent illness/disease explaining thrombocytopenia? <input type="checkbox"/> Yes <input type="checkbox"/> No Was there prior treatment with a reasonable course of corticosteroids or splenectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please specify which drugs were tried and the treatment dates: What is the platelet count? _____ Date: _____
<input type="checkbox"/>	HIV-associated Thrombocytopenia <i>copies of clinical records and lab reports required</i> Is there active bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No What is the current platelet count? _____ Date: _____ Are there any major surgical procedure planned? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Date: _____
<input type="checkbox"/>	Fetal Alloimmune Thrombocytopenia (FAIT) Is there a documentation of maternal antibodies to paternal platelet antigen? <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any previous pregnancies complicated by FAIT? <input type="checkbox"/> Yes <input type="checkbox"/> No Fetal platelet counts if available:
<input type="checkbox"/>	Idiopathic Thrombocytopenic Purpura (ITP) in pregnancy Is there a history of previously delivered infant(s) with autoimmune thrombocytopenia? <input type="checkbox"/> Yes <input type="checkbox"/> No What is the current platelet count? LMP: Is there any bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the thrombocytopenia refractory to steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there a history of splenectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Post-transfusion purpura
<input type="checkbox"/>	Neonatal isoimmune hemolytic disease Is IVIG given in conjunction with phototherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Warm type autoimmune hemolytic anemia Is there a predominance of Ig G (warm) antibodies? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there a failure, contraindication, or intolerance to available alternative therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please mark all that apply: <input type="checkbox"/> azathioprine <input type="checkbox"/> cyclophosphamide <input type="checkbox"/> cyclosporine <input type="checkbox"/> prednisone <input type="checkbox"/> plasmapheresis <input type="checkbox"/> splenectomy ___ <input type="checkbox"/> other (please specify):

<input type="checkbox"/>	<p>Anemia related to chronic parvovirus B19 infection What is the hemoglobin? Is there evidence of viremia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<input type="checkbox"/>	<p>Evan's syndrome Is there a failure, contraindication, or intolerance to available alternative therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please mark all that apply: <input type="checkbox"/> azathioprine <input type="checkbox"/> cyclophosphamide <input type="checkbox"/> cyclosporine <input type="checkbox"/> prednisone</p>
4. Neurology	
<input type="checkbox"/>	<p>Neuropathies:</p> <p><input type="checkbox"/> Acute inflammatory demyelinating polyneuropathy (AIDP) <input type="checkbox"/> Chronic inflammatory demyelinating polyneuropathy (CIDP) <input type="checkbox"/> Multifocal acquired demyelinating sensory and motor neuropathy (MADSAM) (Lewis Sumner Syndrome) <input type="checkbox"/> Multifocal Motor Neuropathy (MMN)</p> <p>Copies of clinical records and lab reports required that includes the following: Comprehensive H&P including duration of symptoms and detailed neurological examination Copy of NCV/EMG reports CSF results including CSF protein, cell count and VDRL Other pertinent tests if applicable, e.g., antibody testing, IPEP, imaging studies</p> <p>For reauthorization requests: Please provide updated progress notes that includes the following information Symptoms and objective exam findings such as strength measurement, sensory testing and reflexes and level of function Titration efforts since last renewal Updated test results (e.g., if NCV/EMG has been repeated)</p>
<input type="checkbox"/>	<p>Myasthenia gravis copies of clinical records and lab reports required: Is a thymectomy planned or has the individual undergone thymectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, on what date? Is the individual initiating immunosuppressive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, which therapy? <i>If the request is for the treatment of acute crisis, please provide clinical documentation of physical findings indicative of acute crisis.</i></p>
<input type="checkbox"/>	<p>Relapsing-Remitting Multiple Sclerosis copies of clinical records and lab / Xray reports required supporting diagnosis and failure of standard therapy: Is there any failure, contraindication, or intolerance to standard conventional therapies (e.g. interferon beta, glatiramer)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which therapies?</p>
<input type="checkbox"/>	<p>Guillain-Barré syndrome (GBS) What was the date of the initial onset of symptoms? Is the individual currently on plasmapheresis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<input type="checkbox"/>	<p>Lambert-Eaton myasthenic syndrome (LEMS) Is there any failure, contraindication, or intolerance to other symptomatic therapies (e.g., acetylcholinesterase inhibitors such as mestinon and immunosuppressants such as prednisone, azathioprine)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which therapies?</p>
<input type="checkbox"/>	<p>Stiff Person Syndrome (Moersch-Woltmann Syndrome) Prior failure, contraindication, or intolerance to available standard medical therapy (please mark all that apply): <input type="checkbox"/> diazepam <input type="checkbox"/> baclofen <input type="checkbox"/> phenytoin <input type="checkbox"/> clonidine <input type="checkbox"/> tizanidine <input type="checkbox"/> Other (please specify):</p>

5. Rheumatologic Disorders

- Dermatomyositis or Polymyositis**
copies of clinical records and lab reports required
Please provide biopsy results;
Does the individual have any failure of standard medical therapy (at least a 4 month trial of corticosteroids and/or immunosuppressants)? Yes No
Is there any profound, rapidly progressive and/or potentially life threatening muscular weakness (refractory or intolerant to previous therapy)? Yes No
Please provide serum creatine kinase (CK) levels
Please provide any muscle strength scales
- Kawasaki disease**
What was the date of the onset of symptoms?
Will IVIG be used in conjunction with aspirin? Yes No

6. Infectious Disease

- Staphylococcal or streptococcal toxic shock syndrome**
Is the infection refractory to treatment? Yes No
If Yes, what therapies have been tried?
Is an undrainable focus present? Yes No
Is persistent oliguria with pulmonary edema present? Yes No
- HIV-positive children and adolescents**
Has the individual been exposed to measles or live in a high-prevalence measles area? Yes No
Will IVIG be used to prevent bacterial infections? Yes No
- Hepatitis A**
Is intramuscular gamma globulin contraindicated? Yes No
If Yes, what is the contraindication?
- Tetanus / Varicella**
Is Tetanus or Varicella Immune Globulin available? Yes No

7. Dermatology

- Pemphigus**
- Pemphigoid**
- Epidermolysis Bullosa Acquisita**

Is there a failure, contraindication, or intolerance to available alternative therapies? Yes No

If Yes, please mark all that apply:

- corticosteroids azathioprine cyclophosphamide
 CellCept other treatment? (please specify):

Does the individual have rapidly progressive disease in which a clinical response can not be affected quickly enough using conventional agents? Yes No

**CIGNA HealthCare's coverage position on this and other medications may be viewed online at:
http://www.cigna.com/customer_care/healthcare_professional/coverage_positions**

Please fax completed form to (800)390-9745. Due to the clinical information required, requests for IVIG cannot be accepted via phone.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to have the request expedited. View our formulary on line at <http://www.cigna.com>.

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