15 Earhart Drive, Suite 101, Amherst, NY 14221

IMMUNE GLOBULIN (IVIG) AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:
Date of birth: Sex: Weight:	Prescriber: Hospital/Clinic:
Home Phone Number:	Phone Number: Fax Number:
Home Address: City: State: Zip:	Address: City: State: Zip:
Payor: ☐Independent Health ☐Anne Arundel Health System ☐Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicaid ☐ Medicare ☐ Self-funded Insurance ID: Group Number:	Notes: Allergies:

☐ New Authorization ☐ Reauthorization

Drug Name: _____

Dose: _____

Frequency: _____

ICD 10 Code: _____

Expected duration of therapy: _____

☐ Patient's plasma IgG level is 2-3 standard deviations outside the mean for age.

☐ Patient has an inability to make specific antibodies which has been verified through either natural exposure or vaccine challenge.

☐ Patient does **NOT** have selective IgA deficiencies.

Please select any of the below criteria that apply to patient:

Primary humoral immunodeficiency disease in patient who is unable to produce sufficient amounts of IgG antibodies

- X-linked agammaglobulinemia
- Common variable immunodeficiency
- Immunoglobulin subclass deficiency
- X-linked immunodeficiency with hyper-IgM
- Combined immunodeficiency including Wiskott-Aldrich syndrome
- Other: _____

Please provide clinical notes and rationale for use.

For Reauthorization, please submit documentation for the following:

- IgG response *(Please attach)*
- Platelet count response *(Please attach)*
- Number of infection episodes or syndromes: _____

_____

_____

- Adverse Effects (ie. Anaphylaxis, Transient Renal Insufficiency, Severe Hypotension): _____

_____

_____

- Compliance with therapy: _____

_____

_____

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