MEDICARE FORM
Immune Globulin (IG) Therapy Medication and/or Infusion Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Alyglo, Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma, Gammagard, Gammaplex, Hyqvia, Panzyga, and Yimmugo are non-preferred. The preferred products are Gammaked, Gamunex-C, Hizentra, Octagam, Privigen and Xembify.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Current Weight: ____ lbs or ____ kgs Height: ____ inches or ____ cms	Allergies:		

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Alyglo** ☐ **Asceniv** ☐ **Bivigam** ☐ **Cutaquig** ☐ **Cuvitru** ☐ **Flebogamma** ☐ **Gamastan S/D** ☐ **Gammaked**
☐ **Gammagard** ☐ **Gammaplex** ☐ **Gamunex-C** ☐ **Hizentra** ☐ **Hyqvia** ☐ **Octagam** ☐ **Panzyga** ☐ **Privigen** ☐ **Xembify** ☐ **Yimmugo**

Dose: _____ **Frequency:** _____ **HCPCS Code:** _____ ☐ **IV** ☐ **IM** ☐ **SC**

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.

Please provide the current immunoglobulin levels:
Immunoglobulin A (IgA) level and date obtained: _____ Date: ____/____/____
Immunoglobulin G (IgG) level and date obtained: _____ Date: ____/____/____
Immunoglobulin M (IgM) level and date obtained: _____ Date: ____/____/____

For All Requests: (Clinical documentation required for all requests)

Note: Alyglo, Asceniv, Bivigam, Cutaquig, Cuvitru, Flebogamma, Gammagard, Gammaplex, Hyqvia, Panzyga and Yimmugo are non-preferred. The preferred products are Gammaked, Gamunex-C, Hizentra, Octagam, Privigen, and Xembify.

☐ Yes ☐ No Has the patient had prior therapy with the requested immune globulin product within the last 365 days?
☐ No Has the patient had a trial and failure of any of the following? (If yes, select all that apply)
☐ Gammaked ☐ Gamunex-C ☐ Hizentra ☐ Octagam ☐ Privigen ☐ Xembify
→ When was the member's trial and failure of the preferred drug? _____
→ Please describe the nature of the failure of the preferred drug _____
☐ No Has the patient had an adverse reaction to any of the following? (If yes, select all that apply)
☐ Gammaked ☐ Gamunex-C ☐ Hizentra ☐ Octagam ☐ Privigen ☐ Xembify
→ When was the member's adverse reaction to the preferred drug? _____
→ Please describe the nature of the adverse reaction to the preferred drug _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

For All requests continued: *Please indicate which of the following applies to the patient and answer subsequent questions*

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply).

☐ Gammaked ☐ Gamunex-C ☐ Hizentra ☐ Octagam ☐ Privigen ☐ Xembify

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☐ Yes ☐ No Is the patient changing to a different immunoglobulin product?

☐ Yes ☐ No Will the requested product be administered in the patient's home?

→ ☐ Yes ☐ No Has the treating practitioner determined that the administration of the requested product in the patient's home is medically necessary and appropriate?

☐ Yes ☐ No Does the patient have immunoglobulin A (IgA) deficiency with anti-IgA antibodies?

☐ Acquired red cell aplasia

☐ Acute disseminated encephalomyelitis

☐ Autoimmune mucocutaneous blistering diseases

Please select which applies to the patient: ☐ Bullous pemphigoid ☐ Epidermolysis bullosa acquisita ☐ Gestational Pemphigoid ☐ Linear IgA disease ☐ Mucous membrane pemphigoid (cicatrical pemphigoid) ☐ Pemphigus vulgaris ☐ Pemphigus foliaceus ☐ None of the above

☐ Yes ☐ No Has patient failed conventional therapy?

→ ☐ Yes ☐ No Does the patient have contraindications to conventional therapy?

→ ☐ Yes ☐ No Does the patient have rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents?

☐ Autoimmune hemolytic anemia (refractory)

☐ Autoimmune neutropenia (refractory)

☐ B-cell chronic lymphocytic leukemia (CLL)

☐ Yes ☐ No Does the patient have hypogammaglobulinemia associated with CLL?

☐ Yes ☐ No Does the patient have recurrent infections or specific antibody deficiency?

☐ Birdshot (vitiligenous) retinochoroidopathy

☐ BK virus associated nephropathy

☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)

☐ Yes ☐ No Has the patient responded to previous intravenous immune globulin (IVIG) therapy?

☐ Churg-Strauss Syndrome (CSS) (allergic granulomatosis)

☐ Yes ☐ No Will IVIG be used as adjunctive therapy for persons with severe active illness?

☐ Yes ☐ No Have other interventions been unsuccessful, become intolerable, or are contraindicated?

→ Please select which applies: ☐ Unsuccessful ☐ Intolerable ☐ Contraindicated

☐ Dermatomyositis

☐ Yes ☐ No Will this be used as adjunctive therapy for persons who have had an inadequate response to first and second line therapies?

☐ Enteroviral meningoencephalitis

☐ Guillain-Barre Syndrome (GBS) and GBS variants

☐ Yes ☐ No Has the patient been diagnosed during the first 2 weeks of illness?

☐ Yes ☐ No Does the patient require aid to walk? (must be severely affected)

☐ Yes ☐ No Does the patient have any contraindications to IVIG?

☐ Hematophagocytic lymphohistiocytosis (HLH) or macrophage activation syndrome (MAS)

☐ Yes ☐ No Does the patient have hypogammaglobulinemia?

→ Please indicate the IgG level: ☐ Less than 400mg/dL ☐ 400mg/dl or greater

☐ Yes ☐ No Is the IgG level two standard deviations below the mean for age?

☐ Hemolytic disease of newborn

☐ Yes ☐ No Is this request to decrease the need for exchange transfusion?

☐ HIV infected children

☐ Yes ☐ No Is this request for bacterial control or prevention of infection?

☐ HIV- associated thrombocytopenia (pediatric or adult)

☐ Hyperimmunoglobulinemia E Syndrome

☐ Yes ☐ No Is this request for treatment of severe eczema?

☐ Immune or Idiopathic thrombocytopenic purpura (ITP)

☐ Yes ☐ No Is a rapid rise in platelet required (such as prior to surgery, to control excessive bleeding, or to defer or avoid splenectomy)?

→ Please provide current platelet count and date collected: _____ Date: ____/____/____

☐ Kawasaki Disease

☐ Lambert-Eaton myasthenic syndrome

☐ Moersch-Woltmann (Stiff-man) syndrome (unresponsive to other therapies)

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

For All requests continued: *Please indicate which of the following applies to the patient and answer subsequent questions*

☐ Multifocal motor neuropathy
- ☐ Yes ☐ No Does the patient have progressive, symptomatic multifocal motor neuropathy?
- ☐ Yes ☐ No Was the diagnosis based on electrophysiologic findings that rule out other possible conditions that may not respond to this treatment?

☐ Multiple Myeloma ☐ Myasthenia Gravis ☐ Neonatal Alloimmune Thrombocytopenia (NAIT) (also known as Fetal Alloimmune Thrombocytopenia or FAIT)
☐ Neonatal Hemochromatosis (prophylaxis) ☐ Opsoclonus-myoclonus ☐ Paraneoplastic opsoclonus-myoclonus-ataxia associated with neuroblastoma
☐ Parvovirus B19 infection (chronic with severe anemia) ☐ Polymyositis in persons who are resistant to first and second line therapies
☐ Post-transfusion purpura ☐ Preparation for thymoma surgery (to prevent myasthenia exacerbation) ☐ Primary humoral immunodeficiency diseases:

Please indicate which of the following applies to the patient:

☐ Congenital agammaglobulinemia (X-linked agammaglobulinemia)	☐ Common variable immunodeficiency	☐ Hyper IgM syndromes
☐ X-linked immunodeficiency with hyperimmunoglobulin M	☐ Hypogammaglobulinemia	☐ Wiscott- Aldrich Syndrome
☐ Immunodeficiency with thymoma (Good Syndrome)	☐ Severe combined immunodeficiency	☐ None of the Above

☐ Rasmussen encephalitis (Rasmussen's Syndrome)
☐ Relapsing-remitting multiple sclerosis (MS)
- ☐ Yes ☐ No Have standard approaches (i.e., interferons) failed, become intolerable, or contraindicated?
- *Please select:* ☐ Standard approaches have failed ☐ Standard approaches have become intolerable ☐ Standard approaches are contraindicated

☐ Renal transplantation from live donor with ABO incompatibility or positive cross-match
- ☐ Yes ☐ No Is a suitable non-reactive live or cadaveric donor unavailable (preparative regimen)?

☐ Secondary immunosuppression associated with major surgery (such as cardiac transplants) and certain diseases (extensive burns, or collagen-vascular diseases)
☐ Selective IgG subclass deficiencies with severe infection for persons meeting selection criteria
☐ Solid organ transplantation
- ☐ Yes ☐ No Will IVIG be used for allosensitized members undergoing solid organ transplant?

☐ Staphylococcal Toxic Shock Syndrome
☐ Stem cell or bone marrow transplantation
☐ Systemic lupus erythematosus (SLE) (for persons with severe active SLE)
- ☐ Yes ☐ No Have other interventions been unsuccessful, become intolerable, or are contraindicated?
  - → Please select: ☐ Unsuccessful ☐ Intolerable ☐ Contraindicated

☐ Toxic epidermal necrolysis (Lyell's syndrome) and Steven-Johnson Syndrome
☐ Toxic shock syndrome or toxic necrotizing fasciitis due to group A streptococcus

For Continuation Requests:(Clinical documentation required for all requests):

☐ Yes ☐ No Has the patient demonstrated an adequate response to therapy? **If *Yes***, please send documentation of the patient's progress (include specific significant or life-threatening infections and dates of occurrences as well as the member's current dosage).
☐ Yes ☐ No Has the patient received IVIG within the past 6 months?
- → ☐ Yes ☐ No Does the patient have a documented severe and/or potentially life-threatening adverse event that occurred during or following the previous infusion?
  - → ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the home or office setting?

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.