Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	_____/_____/_____ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**IVIG**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process.*

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with question set.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Site of Care:

A. At what location will the member be receiving the requested medication?

❑ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.

❑ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting. _____

_____

❑ Other. Please specify. _____

Criteria Questions: **NOTE**: Form must be completed in its **entirety** for processing

Please select medication:

❑ **Asceniv**	❑ **Bivigam**	❑ **Flebogamma**	❑ **Gammagard**	❑ **Gammagard S/D**	❑ **Gammaked**
❑ **Gammaplex**	❑ **Gamunex-C**	❑ **Octagam**	❑ **Panzyga**	❑ **Privigen**	❑ **Carimune NF**

1. Has the patient been on this medication continuously for the last **6 months,** excluding samples? ***Please select answer below:***

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 5**

❑**NO** – this is **INITIATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. Will this medication be filled at a pharmacy or billed through medical plan or office billing? ❒Pharmacy ❒Medical plan/Office billing

4. Will the medication be self-administered? ***Please select answer below:***

❑**Yes**: Has the patient or their caregiver been instructed on how to monitor for signs and symptoms of thrombosis when self-administering the medication? ❑Yes ❑No

❑**No**: Will the patient be monitored carefully for signs and symptoms of thrombosis both at the time of infusion and after infusion? ❑Yes ❑No

5. Will this medication be given with other immune globulin medications? ❑Yes* ❑No
   If YES, specify the medication: _____

6. What is the patient's diagnosis?

❑Fetal Alloimmune Thrombocytopenia (F/NAIT)
❑Inclusion-body myositis
❑Kawasaki syndrome
❑Lambert-Eaton Myasthenic Syndrome (LEMS)
❑Multiple sclerosis
❑Parvovirus B 19-induced Pure Red Cell Aplasia (PRCA)
❑Peripheral Blood Progenitor Cell (PBPC) collection
❑Umbilical cord stem cell transplantation

❑Agammaglobulinemia
   a. Has the patient's diagnosis been confirmed by genetic or molecular testing? ❑Yes ❑No
   b. Does the patient have a pre-treatment IgG less than 200mg/dL? ❑Yes ❑No

❑Ataxia-telangiectasia **OR** ❑DiGeorge syndrome **OR** ❑Wiskott-Aldrich syndrome
   a. Has the patient's diagnosis been confirmed by genetic or molecular testing? ❑Yes ❑No
   b. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No
   c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No

❑Autoimmune encephalitis
   a. Has the diagnosis been confirmed with **TWO** of the following tests: neuroimaging, electroencephalography (EEG), lumbar puncture, or serologic testing? ❑Yes ❑No

❑Bone Marrow Transplantation (BMT) **OR** ❑Hematopoietic Stem Cell Transplant (HSCT) recipients
   a. Is the medication being prescribed for prophylaxis of bacterial and viral infections? ❑Yes ❑No
   b. Has the patient received a transplant in the last 100 days? ❑Yes ❑No*
      If NO, does the patient have a pre-treatment serum IgG level less than 400 mg/dL? ❑Yes ❑No

❑Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
   a. Does the patient have moderate to severe functional disability? ❑Yes ❑No
   b. Has the patient had electro-diagnostic studies (ex: EMG, NCV) that are consistent with multifocal demyelinating abnormalities? ❑Yes ❑No

❑Chronic Lymphocytic Leukemia (CLL)
   a. Does the patient have B-cell type chronic lymphocytic leukemia? ❑Yes ❑No
   b. Is this medication being prescribed for prophylaxis of bacterial and viral infections? ❑Yes ❑No
   c. Is there a documented history of recurrent sinopulmonary infections requiring intravenous antibiotics or hospitalization? ❑Yes ❑No
   d. Does the patient have a pre-treatment serum IgG level less than 500 mg/dL? ❑Yes ❑No

❑Common Variable Immunodeficiency Disease (CVID)
   a. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No
   b. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No
   c. Have other causes of immune deficiency been excluded including drug-induced, genetic disorders, infectious diseases such as HIV, or malignancy? ❑Yes ❑No
   d. Does the patient have a pre-treatment IgG level of less than 500 mg/dL? ❑Yes ❑No*
      If NO, does the patient have a pre-treatment IgG equivalent to 2 or more standard deviations below the mean for the age of the patient? ❑Yes ❑No

❑Dermatomyositis **OR** ❑Polymyositis
   a. Does the patient have documented clinical features such as: elevated muscle enzymes, muscle biopsy or supportive diagnostic tests? ❑Yes ❑No
   b. Has the patient had an inadequate response, intolerance, or contraindication to first-line treatments such as corticosteroids or immunosuppressants? ❑Yes ❑No

❑Guillain-Barre Syndrome (GBS)
   a. Has the patient's physical mobility been severely affected requiring the patient to use an aid to walk? ❑Yes ❑No
   b. Will IVIG therapy be initiated within two weeks of the onset of symptoms? ❑Yes ❑No

❑HIV infections

a. Is the medication being prescribed for prophylaxis of bacterial and viral infections? ❑Yes ❑No

b. Is this medication being used for primary or secondary prophylaxis? ***Please select answer below:***

❑**Primary prophylaxis**: Does the patient have a pre-treatment serum lgG level less than 400 mg/dL? ❑Yes ❑No

❑**Secondary prophylaxis**: Please answer the following questions:

i. Does the patient have documentation of recurrent bacterial and viral infections (greater than 2 serious infections in a year)? ❑Yes ❑No

ii. Does the patient have a contraindication to taking combination antiretroviral therapy? ❑Yes ❑No

iii. Has antibiotic prophylaxis been found to be ineffective for this patient? ❑Yes ❑No

❑Hypogammaglobulinemia

a. Does the patient have a pre-treatment lgG less than 500 mg/dL? ❑Yes ❑No*

***If NO**, does the patient have a pre-treatment lgG equivalent to 2 or more standard deviations below the mean for the patient's age? ❑Yes ❑No

b. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No

c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No

❑lgG subclass deficiency

a. Does the patient have a pre-treatment lgG1, lgG2, or lgG3 equivalent to 2 or more standard deviations below the mean for the patient's age on at least two occasions? ❑Yes ❑No

b. Does the patient have lgG (total) and lgM levels within normal limits? ❑Yes* ❑No

***If YES**, does the patient have lgA levels within low to normal limits? ❑Yes ❑No

c. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No

d. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No

❑Multifocal Motor Neuropathy (MMN)

a. Is the patient experiencing weakness without *objective sensory loss in two or more nerves? ❑Yes ❑No

Objective sensory loss is defined as: decreased reflexes, motor weakness, muscle wasting, trophic skin, join changes

b. Has the patient had electrodiagnostic studies that are consistent with motor conduction block? ❑Yes ❑No

c. Has the patient had sensory nerve conduction studies that are normal? ❑Yes ❑No

❑Myasthenia gravis

a. Has the patient experienced an increase in any of the following symptoms: diplopia (double vision), ptosis (drooping eyelid), blurred vision, dysarthria (difficulty in speech), dysphagia (difficulty swallowing), difficulty chewing, impaired respiratory status, fatigue, or limb weakness? ❑Yes ❑No*

***If NO**, has the patient had *pre-operative management? ❑Yes ❑No

Pre-operative management includes: cholinesterase inhibitors, corticosteroids, or immunosuppressants

❑Secondary immunosuppression

a. Does the patient have secondary immunosuppression associated with hematological malignancy? ❑Yes ❑No

b. Does the patient have a pre-treatment lgG level of less than 500mg/dL? ❑Yes ❑No*

***If NO,** does the patient have a pre-treatment lgG equivalent to 2 or more standard deviations below the mean for the patient's age? ❑Yes ❑No

❑Selective lgA deficiency

a. Does the patient have a pre-treatment lgA level of less than 7mg/dL? ❑Yes* ❑No

***If YES**, does the patient have lgG and lgM levels within normal limits? ❑Yes ❑No

b. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No

c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No

❑Selective lgM deficiency

a. Does the patient have a pre-treatment lgM level of less than 30mg/dL? ❑Yes* ❑No

***If YES**, does the patient have lgG and lgM levels within normal limits? ❑Yes ❑No

b. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No

c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No

❑Severe Combined Immunodeficiency Disease (SCID)

a. Does the patient have an absence or very low number of T cells (CD3 T cells less than 300/microliter)? ❑Yes ❑No*

If NO, is there a presence of maternal T cells in the circulation? ❑Yes ❑No

b. Has the patient's diagnosis been confirmed by genetic or molecular testing? ❑Yes ❑No

c. Does the patient have a pre-treatment lgG less than 200 mg/dL? ❑Yes ❑No

❑Specific antibody deficiency

a. Does the patient have a specific antibody deficiency with lgG, lgA, and lgM levels within normal limits? ❑Yes ❑No

b. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No

c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No

❑Stiff-person syndrome

a. Has the patient had an inadequate response, intolerance, or contraindication to first-line treatment (benzodiazepine or baclofen)? ❑Yes ❑No

❑Idiopathic Thrombocytopenic Purpura (ITP)

a. **FEMALE patient**: Is the patient of reproductive potential? ❑Yes* ❑No

If YES, is the patient currently pregnant? ❑Yes ❑No

b. Has the patient been diagnosed with ITP within the past three months? ***Please select answer below:***

❑**Yes**: Complete **Section A** for patients **under 18 years of age** **OR** Complete **Section B** for patients **18 years of age or older**

i. **SECTION A: Patients UNDER 18 years of age**, please answer the following questions:

1) Does the patient has significant bleeding symptoms such as mucosal bleeding or moderate to severe bleeding? ❑Yes ❑No

2) Is the patient at high risk for bleeding? ❑Yes ❑No

3) Does the patient require a rapid increase in platelets due to a surgery or procedure? ❑Yes ❑No

OR

SECTION B: Patients 18 years of age or older, please answer the following questions:

1) What is the patient's platelet count? ***Please select answer below:***

❑Less than 30,000/mcL

❑30,000 to 49,999/mcL, please answer the following question:

a) Does the patient have significant bleeding symptoms, a high risk for bleeding, or a requirement for a rapid increase in platelets? ❑Yes ❑No

❑50,000/mcL or higher

2) Will IVIG be used in combination with corticosteroid therapy? ❑Yes ❑No*

If NO, does the patient have a contraindication to corticosteroid therapy? ❑Yes ❑No

❑**No**: Please answer the questions below:

i. Is the patient experiencing refractory ITP following a splenectomy? ***Please select answer below:***

❑**Yes**: Does the patient have a platelet count less than 30,000/mcL (microliter)? ❑Yes ❑No*

If NO, does the patient have significant bleeding symptoms? ❑Yes ❑No

❑**No**: Please answer the following questions:

1) What is the patient's platelet count? ***Please select ONE of the following below:***

❑Less than 30,000/mcL

❑30,000/mcL to 49,999/mcL, please answer the following question:

a) Does the patient have significant bleeding or is at high risk for bleeding or have a requirement for a rapid increase in platelets? ❑Yes ❑No

❑50,000/mcL or higher

2) Has the patient had a relapse after a previous response to IVIG? ❑Yes ❑No

3) Has the patient had inadequate response, intolerance or contraindication to corticosteroid therapy? ❑Yes ❑No

❑Other non-SCID combined immunodeficiency ***(please specify):*** _____

a. Has the patient's diagnosis been confirmed by genetic or molecular testing? ❑Yes ❑No

b. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No

c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR CONTINUATION OF THERAPY
Please select medication:

❑ **Asceniv**	❑ **Bivigam**	❑ **Flebogamma**	❑ **Gammagard**	❑ **Gammagard S/D**	❑ **Gammaked**
❑ **Gammaplex**	❑ **Gamunex-C**	❑ **Octagam**	❑ **Panzyga**	❑ **Privigen**	❑ **Carimune NF**

1. Has the patient been on this medication continuously for the last **6 months,** excluding samples? ***Please select answer below***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Will this medication be filled at a pharmacy or billed through medical plan or office billing? ❒Pharmacy ❒Medical plan/Office billing
4. Will the medication be self-administered? ***Please select answer below:***
   ❑**Yes**: Has the patient or their caregiver been instructed on how to monitor for signs and symptoms of thrombosis when self-administering the medication? ❑Yes ❑No
   ❑**No**: Will the patient be monitored carefully for signs and symptoms of thrombosis both at the time of infusion and after infusion? ❑Yes ❑No
5. Will this medication be given with other immune globulin medications? ❑Yes* ❑No
   If YES, specify the medication: _____
6. What is the patient diagnosis?
   ❑Fetal Alloimmune Thrombocytopenia (F/NAIT)
   ❑Guillain-Barre Syndrome (GBS)
   ❑Idiopathic Thrombocytopenic Purpura (ITP)
   ❑Inclusion-body myositis
   ❑Kawasaki syndrome
   ❑Lambert-Eaton Myasthenic Syndrome (LEMS)
   ❑Multiple sclerosis
   ❑Myasthenia gravis
   ❑Parvovirus B 19-induced Pure Red Cell Aplasia (PRCA)
   ❑Peripheral Blood Progenitor Cell (PBPC) collection
   ❑Stiff-person syndrome
   ❑Umbilical cord stem cell transplantation
   ❑Autoimmune encephalitis
      a. Has the patient had a neurological exam that confirmed an improvement and maintenance of improvement since initiation of therapy? ❑Yes ❑No
   ❑Bone Marrow Transplantation (BMT) **OR** ❑Hematopoietic Stem Cell Transplantation (HSCT) recipients
      a. Is the medication being prescribed for prophylaxis of bacterial and viral infections? ❑Yes ❑No
      b. Does the patient have a documented reduction of frequency of bacterial and viral infections since initiation? ❑Yes ❑No
   ❑Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
      a. Is the IVIG being used at the lowest effective dose and frequency? ❑Yes ❑No
      b. Have chronic stable patients been tapered and/or had treatment withdrawn to determine whether continued treatment is necessary? ❑Yes ❑No
      c. Has the patient had a significant improvement in disability and maintenance of improvement since initiation? ❑Yes ❑No
   ❑Chronic Lymphocytic Leukemia (CLL)
      a. Does the patient have B-cell chronic lymphocytic leukemia? ❑Yes ❑No
      b. Does the patient have a documented reduction of frequency of bacterial and viral infections since initiation? ❑Yes ❑No
   ❑Dermatomyositis **OR** ❑Polymyositis
      a. Has the patient had a significant improvement in disability and maintenance of improvement since initiation? ❑Yes ❑No
   ❑HIV infections
      a. Is the medication being prescribed for prophylaxis of bacterial and viral infections? ❑Yes ❑No
      b. Does the patient have a documented reduction of frequency of bacterial and viral infections since initiation? ❑Yes ❑No
   ❑Multifocal Motor Neuropathy (MMN)
      a. Has the patient had a significant improvement in disability and maintenance of improvement since initiation? ❑Yes ❑No

❑Primary Immunodeficiency Disease (PID)

a. What type of primary immunodeficiency disease does the patient have? ***Please select ONE of the following below:***

❑Agammaglobulinemia ❑IgG subclass deficiency ❑Common Variable Immunodeficiency Disease (CVID)
❑Ataxia-telangiectasia ❑Selective lgA deficiency ❑Severe Combined Immunodeficiency Disease (SCID)
❑DiGeorge syndrome ❑Selective lgM deficiency ❑Wiskott-Aldrich syndrome
❑Hypogammaglobulinemia ❑Specific antibody deficiency
❑Other non-SCID combined immunodeficiency ***(please specify)***: _____
❑Other ***(please specify)***: _____

b. Will the patient's lgG trough levels be monitored at least yearly and maintained at or above the lower range of normal for the patient's age? ❑Yes ❑No

c. Does the patient have a documented reduction of frequency of bacterial and viral infections since initiation? ❑Yes ❑No

d. Does the prescriber agree to re-evaluate the dose of the IVIG and reconsider a dose adjustment? ❑Yes ❑No

❑Secondary immunosuppression

a. Does the patient have secondary immunosuppression associated with hematological malignancy? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**
Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320**