SecurityHealth Plan℠
Promises kept, plain and simple.

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 1.877.727.2232 | 715.221.9898

Intravenous Immunoglobulin/Subcutaneous Immunoglobulin Infusion

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number

Medication requested

Intravenous immunoglobulin (IVIG):

☐ Bivigam™ ☐ Carimune® ☐ Flebogamma® ☐ Gammagard® ☐ Gammaked®
☐ Gammaplex® ☐ Gamunex® ☐ Octagam® ☐ Privigen®

Subcutaneous immunoglobulin (SQIG):

☐ Gammagard® ☐ Gammaked® ☐ Gamunex® ☐ Hizentra®

Indicate the diagnosis

☐ Primary immunodeficiency syndrome
- Include medical records with the following:
  - History and physical examination, documenting the severity of the condition, including frequency and severity of infections
  - Clinical deficiency of immunity as evidenced by one of the following:
    - Laboratory results supporting the diagnosis for which immune globulin is requested
    - Documented failure to produce antibodies to specific antigens
    - History of significant recurrent infections

☐ Idiopathic thrombocytopenic purpura (ITP)
- Include medical records with the following:
  - Documentation of diagnosis of idiopathic thrombocytopenic purpura (ITP)
  - Documentation of platelet count less than 50 x 10^9/L

☐ Chronic inflammatory demyelinating polyneuropathy

☐ Initial request: The immune globulin dose does not exceed 2,000 mg/kg given over 2 to 5 consecutive days administered in up to 3 monthly infusions
- Include medical records confirming any checked boxes below:

☐ Member has had symptoms present for at least 2 months
☐ Symptomatic polyradiculoneuropathy as indicated by progressive or relapsing motor or sensory impairment of more than one limb

Electrophysiologic findings:

☐ Partial conduction block of ≥ 1 motor nerve
☐ Reduced conduction velocity of ≥ 2 motor nerves
☐ Prolonged distal latency of ≥ 2 motor nerves
☐ Prolonged F-wave latencies of ≥ 2 motor nerves or the absence of F waves

Lumbar puncture:

☐ White blood cell count <10/mm^3
☐ Elevated CSF protein

☐ Continuation request:
- Include medical records confirming any checked boxes below:
  - ☐ Documentation of positive clinical response to therapy as measured by an objective scale (e.g. Rankin, Modified Rankin, Medical Research Council [MRC] scale)
  - ☐ For long-term treatment, documentation that the dose has been periodically reduced or the treatment withdrawn, and the effects measured
  - ☐ Concomitant immunomodulator therapy (e.g. azathioprine, cyclosporine, methotrexate, prednisone), unless contraindicated
  - ☐ Immune globulin dose does not exceed 2,000 mg/kg given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval may need to be adjusted in patients with severe comorbidities

☐ Other _____

☐ Initial request:
- Include medical records confirming any checked boxes below:
  - ☐ Medical records documenting the severity of the diagnosis, including frequency and severity of infections
  - ☐ Laboratory results supporting the diagnosis for which immune globulin is requested
  - ☐ Documented failure to produce antibodies to specific antigens

☐ Continuation request:
- Include medical records confirming any checked boxes below:
  - ☐ Medical records indicating objective response to therapy, including decreasing frequency, and severity of infections
  - ☐ Documentation of titration to the minimum dose and frequency to maintain a sustained clinical effect
  - ☐ Serum immunoglobulin levels prior to immune globulin therapy and most recent serum IgG trough levels

HCPCS/J-code	
ICD code	
Strength requested	
Dosing schedule/frequency	
Duration of therapy	
Weight of member	
Administration site	☐ Provider office ☐ Home infusion _____ ☐ Outpatient infusion center _____ ☐ Other_____

Comments _____

_____

_____

_____

Provider signature _____ Date _____

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:	Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715.221.9918	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Provider Assistance at 1.800.472.2363.

