



PRIOR AUTHORIZATION REQUEST FORM Immunoglobulin Therapy

DATE OF REQUEST: _____ <u>MEMBER INFORMATION</u> NAME _____ ID # _____ BIRTHDATE _____ <input checked="" type="checkbox"/> PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.	<u>PROVIDER INFORMATION</u> NAME _____ NPI # _____ ADDRESS _____ _____ PHONE # _____ FAX # _____ CONTACT NAME _____ PROVIDER SIGNATURE _____
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Drug Requested: *(please specify which IVIG)* _____

Dose/frequency: _____

<u>Location of administration</u>	<u>Medication being supplied by:</u>
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Home -----(if home - choose vendor (*select one*))----->
 Coram Healthcare Bioscrip Other: _____
 Office Outpatient Hospital: _____ ---> Office/Facility to buy and bill
 Other: _____

- (Effective 12/09) Intravenous Immunoglobulin is to be administered in the home setting, **with the exception of the first dose**, which may be given in a supervised outpatient setting. (EXCEPTION: Medicare, MVP Option, MVP Option Family, MVP Option Child and Healthy New York members are not required to receive IVIG in the home setting.)
- Medical necessity for administering intravenous immunoglobulin in places of service other than the home must be documented in the medical record.

Diagnosis _____ Please check one <input type="checkbox"/> Initial Request	ICD-9 code _____ <input type="checkbox"/> Extension Request
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Previous Medication History	Rationale for Discontinuation

Rationale for Request (co-morbidities, allergies, etc.) _____

Submit chart notes to identify all of the following:

<ul style="list-style-type: none"> All other treatments have been tried Expected duration of requested treatment 	<ul style="list-style-type: none"> Outcome for each previous drug trial All other pertinent information
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PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.

Refer to the MVP Formulary at www.mvphealthcare.com for those drugs that require prior authorization or are subject to quantity limits or step therapy.

FAX THIS REQUEST TO:

Commercial 1-800-376-6373 <i>(HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)</i>	Medicare Part D 1-800-401-0915 <i>(Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)</i>
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