PRIOR AUTHORIZATION REQUEST FORM
Immunoglobulin Therapy

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID # _____

BIRTHDATE _____

☑ 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.

PRESCRIBING PHYSICIAN INFORMATION

NAME _____

NPI # _____

ADDRESS _____

_____

PHONE #_____FAX #_____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Drug Requested: ***(please specify which IVIG)*** _____
Dose/frequency: _____

Place of administration

□ Home *medication will be supplied by (select one):* □ Coram Healthcare □ Upstate Home Care
□ Office *(office to buy and bill)*
□ Outpatient Hospital Hospital Name_____
□ Other _____
*** If covered under the Part D benefit, may be supplied by any contracted provider*

- Immunoglobulin therapy is to be administered in the home setting, **with the exception of the first dose**, which may be given in a supervised outpatient setting.
- Medical necessity for administering immunoglobulin in places of service other than the home must be documented in the medical record. (EXCEPTION: Medicare and Medicaid members are not required to receive IVIG in the home setting.)

Diagnosis_____ **ICD-10 code** _____
Please check one □ **Initial Request** □ **Extension Request**

Previous Medication History	**Rationale for Discontinuation**

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

Submit chart notes to identify all of the following:
- All other treatments have been tried
- Expected duration of requested treatment
- Outcome for each previous drug trial
- All other pertinent information

☑ **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**
(HMO, EPO/PPO, Exchange, Medicaid, Child Health Plus, ASO)

Medicare Part D **1-800-401-0915**
(Preferred Gold, Gold PPO, GoldValue, BasiCare, USA Care, MVP RxCare)