CIGNA
Pharmacy Services
Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form
- IVIG (Intravenous Immune Globulin)-

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested:

☐ Gamimune N	☐ Gammar	☐ Polygam S/D	☐ Gammagard S/D	☐ Gammagard Liquid
☐ Carimune	☐ Carimune NF	☐ Panglobulin NF	☐ Venoglobulin-S	☐ Immune Globulin, Gamma
☐ Baygam	☐ Flebogamma	☐ Iveegam EN	☐ Other (Please specify):	

Dose requested: Dose (mg/kg): JCode: CPT Code:

Frequency of administration: Duration of therapy: Patient's current weight:

Where will this medication be obtained?

☐ CIGNA Tel-Drug *(CIGNA's nationally preferred specialty pharmacy)*
☐ Prescriber's office stock (billing on a medical claim form)
☐ Home Health / Home Infusion vendor (name):
Address: TIN#:
☐ Retail pharmacy
☐ Other (please specify):

Please specify the following:

Has this patient been treated with IVIG in the past? ☐Yes ☐ No
If Yes, please complete reauthorization criteria in addition to the diagnosis specific criteria on this form.

1. Primary Immunodeficiency	
☐	Congenital / X-linked agammaglobulinemia-(XLA) Bruton's Disease
☐	Autosomal recessive agammaglobinulinemia – (ARA)
☐	Autosomal recessive hyper-IgM syndrome (HIM)
☐	Congenital Hypogammaglobulinemia
☐	ICF Syndrome
☐	Common variable immunodeficiency (CVID)
☐	Selective IgA Deficiency
☐	Selective IgG subclass deficiencies (IGGSD)

☐	Specific Antibody Deficiency (SAD)
☐	Transient hypogammaglobulinemia of infancy
☐	Hypogammaglobulinemia, unspecified
☐	Severe combined immunodeficiency disorder (SCID)
☐	Wiskott Aldrich syndrome (WAS)
☐	Ataxia-telangiectasia (A-T) including (NBS)
☐	DiGeorge syndrome (DGS)
☐	Hyper-IgM syndrome
☐	X-linked lymphoproliferative syndrome
☐	(WHIM) warts, hypogammaglobulinemia, immunodeficiency, and myelokathexis
☐	Defects of NF-κB regulation Defects of Toll-like receptor signaling
☐	Other (please specify):

Pre Treatment Immunoglobulin levels
copies of lab reports required, including:
Total immunoglobulin levels:
Ig G subclasses (if applicable):
B cells (if applicable):
Genetic testing confirming the diagnosis (if applicable):

Vaccine response results
copies of lab reports required, **including**
pre & post vaccination responses for pneumococcal, diphtheria, tetanus vaccines

Details of recurrent infections
copies of clinical records required that address the following*:*
Sites of infections:
When did the infections start?
How many episodes per year?
How many courses of antibiotics per year?
List of the names of antibiotics and durations:
Are underlying conditions such as asthma, allergic rhinitis under control? ☐Yes ☐ No
Supporting diagnostic imaging or lab results of recurrent infections where applicable:

For reauthorization requests
copies of clinical records required, including:
Trough Ig G levels:
Response to IVIG:

2. Secondary Immunodeficiency	
☐	**High-risk, preterm, low-birth-weight neonates**
☐	**Multiple Myeloma** ***copies of clinical records and lab reports required:*** Has the disease been stable for 3 months? ☐Yes ☐ No Pre treatment Ig G level: Number of recurrent sino pulmonary infections per year:
☐	**CLL** ***copies of clinical records and lab reports required:*** Pre treatment Ig G level: Number of recurrent sino pulmonary infections per year:

☐	**Allogeneic hematopoietic stem cell transplant (HSCT)** ***copies of clinical records and lab reports required:*** Date of transplant: Pre treatment Ig G levels: Number of recurrent sino pulmonary infections per year:
☐	**Allosensitized solid organ transplants**
☐	**Bone marrow transplantation** Date of transplant:
☐	**HIV** CD 4 counts: Current antiretroviral medications:
	3. Hematology
☐	**Acute Idiopathic Thrombocytopenic Purpura (ITP)** Is there active bleeding? ☐Yes ☐ No What is the platelet count? Date: Are there any major surgical procedures planned? ☐Yes ☐ No Date:
☐	**Chronic Idiopathic Thrombocytopenic Purpura (ITP)** ***copies of clinical records and lab reports required:*** What is the duration of ITP? Are there any other concurrent illness/disease explaining thrombocytopenia? ☐Yes ☐ No Was there prior treatment with a reasonable course of corticosteroids or splenectomy? ☐Yes ☐ No If Yes, please specify which drugs were tried and the treatment dates: What is the platelet count? Date:
☐	**HIV-associated Thrombocytopenia** ***copies of clinical records and lab reports required*** Is there active bleeding? ☐Yes ☐ No What is the current platelet count? Date: Are there any major surgical procedure planned? ☐Yes ☐ No Date:
☐	**Fetal Alloimmune Thrombocytopenia (FAIT)** Is there a documentation of maternal antibodies to paternal platelet antigen? ☐Yes ☐ No Are there any previous pregnancies complicated by FAIT? ☐Yes ☐ No Fetal platelet counts if available:
☐	**Idiopathic Thrombocytopenic Purpura (ITP) in pregnancy** Is there a history of previously delivered infant(s) with autoimmune thrombocytopenia? ☐Yes ☐ No What is the current platelet count? LMP: Is there any bleeding? ☐Yes ☐ No Is the thrombocytopenia refractory to steroids? ☐Yes ☐ No Is there a history of splenectomy? ☐Yes ☐ No
☐	**Post-transfusion purpura**
☐	**Neonatal isoimmune hemolytic disease** Is IVIG given in conjunction with phototherapy? ☐Yes ☐ No
☐	**Warm type autoimmune hemolytic anemia** Is there a predominance of Ig G (warm) antibodies? ☐Yes ☐ No Is there a failure, contraindication, or intolerance to available alternative therapies? ☐Yes ☐ No If Yes, please mark all that apply: ☐ azathioprine ☐ cyclophosphamide ☐ cyclosporine ☐ prednisone ☐ plasmapheresis ☐ splenectomy ☐ other (please specify):

☐ **Anemia related to chronic parvovirus B19 infection**
What is the hemoglobin?
Is there evidence of viremia? ☐Yes ☐ No

☐ **Evan's syndrome**
Is there a failure, contraindication, or intolerance to available alternative therapies? ☐Yes ☐ No
If Yes, please mark all that apply:
☐ azathioprine ☐ cyclophosphamide ☐ cyclosporine ☐ prednisone

4. Neurology

☐ **Neuropathies**:

☐ Acute inflammatory demyelinating polyneuropathy (AIDP)
☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)
☐ Multifocal acquired demyelinating sensory and motor neuropathy (MADSAM) (Lewis Sumner Syndrome)
☐ Multifocal Motor Neuropathy (MMN)

Copies of clinical records and lab reports required that includes the following:
Comprehensive H&P including duration of symptoms and detailed neurological examination
Copy of NCV/EMG reports
CSF results including CSF protein, cell count and VDRL
Other pertinent tests if applicable, e.g., antibody testing, IPEP, imaging studies

For reauthorization requests:
Please provide updated progress notes that includes the following information
Symptoms and objective exam findings such as strength measurement, sensory testing and reflexes and level of function
Titration efforts since last renewal
Updated test results (e.g., if NCV/EMG has been repeated)

☐ **Myasthenia gravis**
copies of clinical records and lab reports required:
Is a thymectomy planned or has the individual undergone thymectomy? ☐Yes ☐ No
If Yes, on what date?
Is the individual initiating immunosuppressive treatment? ☐Yes ☐ No
If Yes, which therapy?
If the request is for the treatment of acute crisis, please provide clinical documentation of physical findings indicative of acute crisis.

☐ **Relapsing-Remitting Multiple Sclerosis**
copies of clinical records and lab / Xray reports required supporting diagnosis and failure of standard therapy:
Is there any failure, contraindication, or intolerance to standard conventional therapies (e.g. interferon beta, glatiramer)?
☐Yes ☐ No
If so, which therapies?

☐ **Guillain-Barré syndrome (GBS)**
What was the date of the initial onset of symptoms?
Is the individual currently on plasmapheresis? ☐Yes ☐ No

☐ **Lambert-Eaton myasthenic syndrome (LEMS)**
Is there any failure, contraindication, or intolerance to other symptomatic therapies (e.g., acetylcholinesterase inhibitors such as mestinon and immunosuppressants such as prednisone, azathioprine)? ☐Yes ☐ No

If so, which therapies?

☐ **Stiff Person Syndrome (Moersch-Woltmann Syndrome)**
Prior failure, contraindication, or intolerance to available standard medical therapy (please mark all that apply):
☐ diazepam ☐ baclofen ☐ phenytoin
☐ clonidine ☐ tizanidine ☐ Other (please specify):

5. Rheumatologic Disorders	
☐	**Dermatomyositis or Polymyositis** ***copies of clinical records and lab reports required*** Please provide biopsy results; Does the individual have any failure of standard medical therapy (at least a 4 month trial of corticosteroids and/or immunosuppressants)? ☐Yes ☐ No Is there any profound, rapidly progressive and/or potentially life threatening muscular weakness (refractory or intolerant to previous therapy)? ☐Yes ☐ No Please provide serum creatine kinase (CK) levels Please provide any muscle strength scales
☐	**Kawasaki disease** What was the date of the onset of symptoms? Will IVIG be used in conjunction with aspirin? ☐Yes ☐ No
6. Infectious Disease	
☐	**Staphylococcal or streptococcal toxic shock syndrome** Is the infection refractory to treatment? ☐Yes ☐ No If Yes, what therapies have been tried? Is an undrainable focus present? ☐Yes ☐ No Is persistent oliguria with pulmonary edema present? ☐Yes ☐ No
☐	**HIV-positive children and adolescents** Has the individual been exposed to measles or live in a high-prevalence measles area? ☐Yes ☐ No Will IVIG be used to prevent bacterial infections? ☐Yes ☐ No
☐	**Hepatitis A** Is intramuscular gamma globulin contraindicated? ☐Yes ☐ No If Yes, what is the contraindication?
☐	**Tetanus / Varicella** Is Tetanus or Varicella Immune Globulin available? ☐Yes ☐ No
7. Dermatology	
☐	**Pemphigus**
☐	**Pemphigoid**
☐	**Epidermolysis Bullosa Acquisita**

Is there a failure, contraindication, or intolerance to available alternative therapies? ☐Yes ☐ No

If Yes, please mark all that apply:

☐ corticosteroids ☐ azathioprine ☐ cyclophosphamide
☐ CellCept ☐ other treatment? (please specify):

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

CIGNA HealthCare's coverage position on this and other medications may be viewed online at: http://www.cigna.com/customer_care/healthcare_professional/coverage_positions

Please fax completed form to (800)390-9745. Due to the clinical information required, requests for IVIG cannot be accepted via phone.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to have the request expedited. View our formulary on line at http://www.cigna.com.