Neighborhood Health Plan OF RHODE ISLAND™

IVIG Authorization form

Tel. 401-427-8200; Fax 844-639-7906

Immune Globulins Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906
**** see chart for J Codes**

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:
REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:
ICD 10 Codes:		

Clinical Assessment (provide all required information and clinical documents)	YES	NO
Is dosing within the FDA guidelines (Please provide medication, strength and direction for use) for all initial and continuation of therapy requests?	□	□
Criteria for Primary immunodeficiency:		
Does the member have a diagnosis of severe combined immunodeficiency (SCID) or congenital agammaglobulinemia (eg, X-linked or autosomal recessive agammaglobulinemia) AND the diagnosis been confirmed by genetic or molecular testing, OR Pretreatment IgG level < 200 mg/dL, OR Absence or very low number of T cells (CD3 T cells < 300/microliter) or the presence of maternal T cells in the circulation (SCID only)?	□	□
Does the patient have Wiskott-Aldrich syndrome, DiGeorge syndrome, or ataxia-telangiectasia (or other non-SCID combined immunodeficiency) AND the diagnosis is confirmed by genetic or molecular testing AND history of recurrent bacterial infections (eg, pneumonia, otitis media, sinusitis) AND impaired antibody response to pneumococcal polysaccharide vaccine?	□	□

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Does the patient have a diagnosis of Common variable immunodeficiency (CVID) and 4 years of age or older, Other causes of immune deficiency have been excluded (eg, drug induced, genetic disorders, infectious diseases such as HIV, malignancy), Pretreatment IgG level < 500 mg/dL or ≥ 2 SD below the mean for age, History of recurrent bacterial infections and Impaired antibody response to pneumococcal polysaccharide vaccine?	☐	☐
Does the patient have Hypogammaglobulinemia (unspecified), IgG subclass deficiency, selective IgA deficiency, selective IgM deficiency, or specific antibody deficiency and	☐	☐
a. History of recurrent bacterial infections	☐	☐
b. Impaired antibody response to pneumococcal polysaccharide vaccine	☐	☐
c. Any of the following pre-treatment laboratory findings: i. Hypogammaglobulinemia: IgG < 500 mg/dL or ≥ 2 SD below the mean for age ii. Selective IgA deficiency: IgA level < 7 mg/dL with normal IgG and IgM levels iii. Selective IgM deficiency: IgM level < 30 mg/dL with normal IgG and IgA levels iv. IgG subclass deficiency: IgG1, IgG2, or IgG3 ≥ 2 SD below mean for age assessed on at least 2 occasions; normal IgG (total) and IgM levels, normal/low IgA levels v. Specific antibody deficiency: normal IgG, IgA and IgM levels	☐	☐
Continuation of therapy: Has the patient a reduction in frequency of bacterial infections has been demonstrated since initiation of IVIG therapy?	☐	☐
Are the IgG trough levels are monitored at least yearly and maintained at or above the lower range of normal for age (when applicable for indication), OR the prescriber will re-evaluate the dose of IVIG and consider a dose adjustment (when appropriate)?	☐	☐
	☐	☐
Does the patient have Myasthenia Gravis with acute exacerbation, worsening weakness or in preparation for surgery:	☐	☐
a. Worsening weakness includes an increase in any of the following symptoms: diplopia, ptosis, blurred vision, difficulty speaking (dysarthria), difficulty swallowing (dysphagia), and difficulty chewing, impaired respiratory status, fatigue, and limb weakness.	☐	☐
b. Acute exacerbations include more severe swallowing difficulties and/or respiratory failure	☐	☐
c. Pre-operative management (eg, prior to thymectomy)	☐	☐
For patients with refractory myasthenia gravis have they tried and failed two or more of standard therapies (eg, corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, rituximab)?	☐	☐
Does the patient have a diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy(CIPD) and have moderate to severe functional disability and the diagnosis was confirmed by electrodiagnostic studies and the evaluation of cerebrospinal fluid (CSF)?	☐	☐
Continuation of therapy for CIDP:	☐	☐
a. Does the patient have significant improvement in disability and maintenance of improvement since initiation of IVIG therapy?	☐	☐

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b. Is IVIG is being used at the lowest effective dose and frequency?	☐	☐
Does the patient have a diagnosis of Dermatomyositis or Polymyositis? AND	☐	☐
a. Has the diagnosis ben established by clinical features (eg, proximal weakness, rash), elevated muscle enzyme levels, electrodiagnostic studies, and muscle biopsy (when available); supportive diagnostic tests include autoantibody testing and muscle imaging (eg, MRI)?	☐	☐
b. Have standard first line treatments (such as corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated, OR the patient is unable to receive standard first-line therapy because of a contraindication or other clinical reason?	☐	☐
Continuation of therapy for Dermatomyositis or Polymyositis:	☐	☐
a. Does the patient have significant improvement in disability and maintenance of improvement since initiation of IVIG therapy?		
Is the patient newly diagnosed with Idiopathic Thrombocytopenia purpura (ITP) (within the past 3 months) or initial therapy:	☐	☐
a. **Children (< 18 years of age)**	☐	☐
i. Significant bleeding symptoms (mucosal bleeding or other moderate/severe bleeding) OR	☐	☐
ii. High risk for bleeding, OR	☐	☐
iii. Rapid increase in platelets is required(eg, surgery or procedure)	☐	☐
b. **Adults (≥ 18 years of age)**		
i. Platelet count < 30,000/mcL, OR	☐	☐
ii. Platelet count < 50,000/mcL and significant bleeding symptoms, high risk for bleeding or rapid increase in platelets is required, AND	☐	☐
iii. Corticosteroid therapy is contraindicated and IVIG will be used alone or IVIG will be used in combination with corticosteroid therapy	☐	☐
Does the patient have a diagnosis of chronic ITP (≥ 3 months from diagnosis) or ITP unresponsive to first-line therapy:	☐	☐
a. Platelet count < 30,000/mcL, OR Platelet count < 50,000/mcL and significant bleeding symptoms, high risk for bleeding or rapid increase in platelets is required, AND	☐	☐
c. Relapse after previous response to IVIG or inadequate response, intolerance, or contraindication to corticosteroid or anti-D therapy?	☐	☐
Does the patient have a diagnosis of refractory ITP after splenectomy:	☐	☐
a. Platelet count < 30,000/mcL,OR		
b. Significant bleeding symptoms	☐	☐
Does the patient have a diagnosis of B-cell Chronic Lymphocytic Leukemia (CLL)?	☐	☐
a. IVIG is prescribed for prophylaxis of bacterial infections.		

b. Patient has a history of recurrent sinopulmonary infections requiring intravenous antibiotics or hospitalization.	☐	☐
c. Patient has a pretreatment serum IgG level	☐	☐
Continuation of therapy for CLL: a. Has a reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy?	☐	☐
Is IVIG being used for Prophylaxis of Bacterial Infections in HIV-Infected Pediatric Patients?	☐	☐
a. Member is ≤ 12 years of age?	☐	☐
b. IVIG is prescribed for primary prophylaxis of bacterial infections and pretreatment serum IgG < 400 mg/dL, OR	☐	☐
c. IVIG is prescribed for secondary prophylaxis of bacterial infections for members with a history of recurrent bacterial infections (> 2 serious bacterial infections in a 1-year period)?	☐	☐
Continuation of therapy for Prophylaxis of Bacterial Infections in HIV-Infected Pediatric Patients: Has the patient had a Reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy?	☐	☐
	☐	☐
Is IVIG being used for Prophylaxis of Bacterial Infections in BMT/HSCT Recipients?	☐	☐
a. IVIG is prescribed for prophylaxis of bacterial infections.	☐	☐
b. Either of the following: IVIG is requested within the first 100 days post-transplant OR	☐	☐
c. Member has a pretreatment serum IgG < 400 mg/dL.	☐	☐
Continuation of therapy for Prophylaxis of Bacterial Infections in BMT/HSCT Recipients:	☐	☐
a. Has the patient had a Reduction in the frequency of bacterial infections since initiation of IVIG therapy?	☐	☐
Does the patient have a diagnosis of Multifocal Motor Neuropathy (MMN) and:	☐	☐
a. Weakness without objective sensory loss in 2 or more nerves?	☐	☐
b. The diagnosis was confirmed by electrodiagnostic studies?	☐	☐
Continuation of therapy for MMN: a. A significant improvement in disability and maintenance of improvement since initiation of IVIG therapy?	☐	☐

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Does the patient have one of the following diagnosis with clinical documentation and dosing is dosing within FDA recommended guidelines: a. Guillain-Barre Syndrome (GBS) b. Lambert-Eaton Myasthenic Syndrome (LEMS) c. Kawasaki Syndrome in pediatric patients d. Fetal/Neonatal Alloimmune Thrombocytopenia (F/NAIT) e. Parvovirus B19-induced Pure Red Cell Aplasia (PRCA) f. Stiff-person Syndrome	☐	☐

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	☐
Signature of Requesting Provider:	**Date:**

Required Documentation:

1. For Primary immunodeficiency(Congenital agammaglobulinemia, Hypogammaglobulinemia, Common Variable Immunodeficiency, Severe combined immunodeficiency , Wiskott-Aldrich syndrome, X-linked agammaglobulinemia or Bruton's Hypergammaglobulinemia, and X-linked Hyper IgM syndrome):
    a. Diagnostic test results (when applicable) are required:
        i. Copy of laboratory with serum immunoglobulin levels: IgG, IgA, IgM, and IgG subclasses
        ii. Vaccine response to pneumococcal polysaccharide vaccine (post-vaccination Streptococcus pneumoniae antibody titers)
        iii. Pertinent genetic or molecular testing in members with a known genetic disorder
        iv. Copy of laboratory report with lymphocyte subset enumeration by flow cytometry
2. IgG trough level for those continuing with IVIG therapy
3. Secondary hypogammaglobulinemia (CLL, HIV, BMT/HSCT recipients): Copy of laboratory report with pre-treatment serum IgG level (when applicable)
4. Chronic inflammatory demyelinating polyneuropathy (CIDP) and multifocal motor neuropathy (MMN):
    a. Pre-treatment electrodiagnostic studies (electromyography [EMG] or nerve conduction studies [NCS])
    b. For CIDP, pre-treatment cerebrospinal fluid (CSF) analysis (when available)
5. Dermatomyositis and polymyositis:
    a. Pre-treatment electrodiagnostic studies (EMG/NCS)
    b. Pre-treatment muscle biopsy report (when available)

Authorization is not a guarantee of payment. Member must be eligible at time of service.

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HCPCS codes	
J0850	Injection, cytomegalovirus immune globulin
J1459	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1460	Injection, gamma globulin, intramuscular, 1 cc
J1555	Injection, human, for use in subcutaneous infusions, 100mg, each
J1556	Injection, immune globulin (Bivigam), 500 mg
J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1559	Injection, immune globulin (Hizentra), 100 mg
J1560	Injection, gamma globulin, intramuscular, over 10 cc
J1561	Injection, immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g., liquid), 500 mg
J1566	Injection, immune globulin, intravenous lyophilized (e.g., powder), not otherwise specified, 500 mg [Carimune, Gammagard S/D]
J1568	Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard Liquid), non-lyophilized (e.g., liquid), 500 mg
J1572	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g., liquid); 500 mg
J1575	Injection, immune globulin/hyaluronidase, (HyQvia), 100 mg immune globulin
J1599	Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg
CPT Codes	
90281	Immune globulin (Ig), human, for intramuscular use [when specified for disease treatment as described in this document]
90283	Immune globulin, (IgIV), human, for intravenous use
90284	Immune globulin, (SCIg), human, for use in subcutaneous infusions, 100 mg each
S9338	Home infusion therapy; immunotherapy, administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment, per diem
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis(specify substance or drug), initial, up to 1 hour
96366	Intravenous infusion ,Each additional hour
96372	Therapeutic, prophylaxis, or diagnostic injection(specify substance or drug); subcutaneous or intramuscular
96369	Subcutaneous infusion, for therapy, prophylaxis, or diagnosis(specify substance or drug), initial, up to 1 hour, including pump set up
96370	Subcutaneous infusion, each additional hour
96371	Additional pump set up, with establishment of new subcutaneous infusion site