Coverage Determination Request Form – Immune Globulins (Medicare B vs. D)

This request is: ☐ **Expedited* (Urgent)** ☐ **Standard** (**Non-Urgent)**

*Expedited means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Please note: All information below is required to process this request. Any information that is incomplete or illegible will delay the review process.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Medication Information (required)		
Indicate Medication Requested: (NOTE: Drugs below are a representative list, only. See plan formulary to verify coverage status.) ☐ BIVIGAM ☐ CARIMUNE ☐ CUVITRU ☐ FLEBOGAMMA ☐ GAMASTAN ☐ GAMMAGARD ☐ GAMMAKED ☐ GAMMAPLEX ☐ GAMUNEX ☐ HIZENTRA ☐ OCTAGAM ☐ PRIVIGEN ☐ Other: _____	Strength:	Dosage Form:
Quantity Prescribed:	Directions for Use:	

B vs. D Primary Billing Determination (required – complete Section A, B, or C)

Section A: <u>Subcutaneous</u> (SC) administration of Hizentra, Gammagard, Gammaked, or Gamunex:

1) Where does the patient reside?

☐ Nursing Facility/Long-Term Care ***(Complete Part D Coverage Determination Criteria section below)***

☐ Home setting *(Continue to Question 2)*

NOTE: *LTC setting is defined as NCPDP Pt Residence Code = 3 or 9; all other codes are considered "Home" setting for BvD for drugs listed above.*

2) Is the requested product prescribed for a primary immune deficiency disease (including ICD-10 D80.0, D80.5, D81.0, D81.1, D81.2, D81.6, D81.7, D81.89, D81.9, D82.0, D83.0, D83.1, D83.2, D83.8, and D83.9)?

☐ Yes - Please provide diagnosis/ICD-10 code: _____ ***(Bill to Medicare Part B)***

☐ No ***(Complete Part D Coverage Determination Criteria section below)***

Section B: <u>Intravenous</u> (IV) administration of an immune globulin product:

1) Is the requested product prescribed for a primary immune deficiency disease (including ICD-10 D80.0, D80.5, D81.0, D81.1, D81.2, D81.6, D81.7, D81.89, D81.9, D82.0, D83.0, D83.1, D83.2, D83.8, and D83.9)?

☐ Yes - Please provide diagnosis/ICD-10 code: _____ ***(Bill to Medicare Part B)***

☐ No ***(Complete Part D Coverage Determination Criteria section below)***

Section C: <u>Intramuscular</u> (IM) administration of Gamastan:

1) Is the requested product prescribed for post-exposure prophylaxis due to hepatitis A, measles, rubella, or varicella exposure?

☐ Yes ***(Bill to Medicare Part B)***

☐ No *(Continue to Question 2)*

2) Is the requested product prescribed for a primary immune deficiency disease (including ICD-10 D80.0, D80.5, D81.0, D81.1, D81.2, D81.6, D81.7, D81.89, D81.9, D82.0, D83.0, D83.1, D83.2, D83.8, and D83.9)?

☐ Yes - Please provide diagnosis/ICD-10 code: _____ ***(Bill to Medicare Part B)***

☐ No ***(Complete Part D Coverage Determination Criteria section below)***

Part D Coverage Determination Criteria (required)

The following requirements need to be met before this drug can be covered by the Part D plan. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Which condition is the drug being used for?

☐ Indicate Diagnosis: _____ ICD-10 Code (s): _____

Please Note: This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the Food and Drug Administration (FDA) – that is, that the FDA has approved the drug for the diagnosis or condition for which it is being prescribed.
- Supported by any of the following reference books – American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and/or the USPDI or its successor.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other pertinent information the physician feels is important to this review? ☐ Yes ☐ No (If yes, please explain, below)

_____

_____

_____

Exception Requests (optional)

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would this medication likely be the most effective option for this patient? ☐ Yes ☐ No
(If yes, please explain why, below)

_____

_____

_____

If the patient is currently using this medication, would changing the current regimen likely result in adverse effects for the patient? ☐ Yes ☐ No (If yes, please explain why, below)

_____

_____

_____

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

Please Note:

- This request may be denied or dismissed unless all required information is received.
- Your office will receive a response via fax.
- For urgent requests, please call (866) 270-3877.
- For real time submission 24/7 please visit the secure prescriber portal on our plan's website for the appropriate form and instructions on how to submit your request.

Authorization Period: 1 Year - subject to formulary change and member eligibility (as well as member place of residence when applicable).

PLEASE FAX COMPLETED FORM TO: 855-668-8552