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

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** (decision within 24 hours) ☐ **Standard (Non-Urgent)** (decision within 72 hours) *If the requestor or prescriber believe that waiting 72 hours for a standard decision could seriously harm the member's life, health, or ability to regain maximum function, an expedited (fast) decision can be requested. If the prescriber indicates that waiting 72 hours could seriously harm the member's health, a decision will automatically be made within 24 hours. If the prescriber's support for an expedited request is not obtained, the request will be reviewed to determine if a fast decision is required.

Please Note: All information below is required to process this request. Any information that is incomplete or illegible will delay the review process. If the request is asking for an EXCEPTION, the prescriber MUST provide a statement supporting the request and the request cannot be processed without one. Please submit all **FORMULARY EXCEPTION** requests on the standard **CMS COVERAGE DETERMINATION** form. Requests that are subject to Prior Authorization (or any other utilization management requirement), may require supporting information.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber 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:

Requestor Information (required if not requested by the member or prescriber)
An individual other than the member or prescriber (such as a family member or friend) may make a request on behalf of the member provided that the individual is a representative. **Documentation must be attached** showing the individual's authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact the plan or 1-800-Medicare.

Requestor Name:	Requestor Phone:	
Requestor Address:	Relationship to Member:	
City:	State:	Zip:

Please fill out the following information:

1. Indicate Medication Requested: (NOTE: Drugs below are a representative list, only. See plan formulary to verify coverage status.)

- ☐ BIVIGAM (Go to #2)
- ☐ FLEBOGAMMA (Go to #2)
- ☐ GAMMAGARD (Go to #2)
- ☐ GAMMAKED (Go to #2)
- ☐ GAMMAPLEX (Go to #2)
- ☐ GAMUNEX-C (Go to #2)
- ☐ OCTAGAM (Go to #2)
- ☐ PANZYGA (Go to #2)
- ☐ PRIVIGEN (Go to #2)
- ☐ Other (Go to #2)

2. Quantity Prescribed: (Go to #3)

3. Dosage Form: (Go to #4)

4. Strength & Route of Administration: (Go to #5)

5. Directions for Use (include frequency and expected length of therapy): (Go to #6)

B vs. D Primary Billing Determination (required)

6. Please indicate route of administration for the medication requested:

- ☐ Subcutaneous (SC) administration (Go to #7)
- ☐ Intravenous (IV) administration (Go to #12)
- ☐ Intramuscular (IM) administration (Go to #16)

Subcutaneous (SC) administration of GAMMAGARD, GAMMAKED, or GAMUNEX

7. Where does the patient reside?
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.*

- ☐ Nursing Facility/Long-Term Care
(Complete Part D Coverage Determination Criteria section below) (Go to #19)
- ☐ Home Setting (Go to #8)

8. Is the requested product prescribed for a primary immune deficiency disease (including ICD-10 G11.3, D80.0, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D81.0, D81.1, D81.2, D81.5, D81.6, D81.7, D81.82, D81.89, D81.9, D82.0, D82.1, D82.4, D83.0, D83.1, D83.2, D83.8, and D83.9)?

- ◯ Yes (Go to #9)
- ◯ No ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #19)

9. Please provide diagnosis/ICD-10 code: (Go to #10)

10. Are ALL of the following criteria met?
- Parenteral administration of the drug in the home is reasonable and necessary
- An infusion pump is necessary to safely administer the drug
- The drug is administered by a prolonged infusion of at least 8 hours because of proven improved clinical efficacy
- The therapeutic regimen is proven or generally accepted to have significant advantages over intermittent bolus administration regimens or infusions lasting less than 8 hours

◯ Yes ***(Bill to Medicare Part B)*** (END)

◯ No (Go to #11)

11. Are ALL of the following criteria met?
- Parenteral administration of the drug in the home is reasonable and necessary
- An infusion pump is necessary to safely administer the drug
- The drug is administered by intermittent infusion (each episode of infusion lasting less than 8 hours) which does not require the beneficiary to return to the practitioner's office prior to the beginning of each infusion
- Systemic toxicity or adverse effects of the drug are unavoidable without infusing it at a strictly controlled rate as indicated in the Physicians' Desk Reference, or the U.S. Pharmacopeia Drug Information

◯ Yes ***(Bill to Medicare Part B)*** (END)

◯ No ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #19)

Intravenous (IV) administration of an immune globulin product

12. Is the requested product prescribed for a primary immune deficiency disease (including ICD-10 G11.3, D80.0, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D81.0, D81.1, D81.2, D81.5, D81.6, D81.7, D81.82, D81.89, D81.9, D82.0, D82.1, D82.4, D83.0, D83.1, D83.2, D83.8, and D83.9)?

◯ Yes (Go to #13)

◯ No ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #19)

13. Please provide diagnosis/ICD-10 code: (Go to #14)

14. Where is the requested medication being administered?

- ◯ Home setting ***(Bill to Medicare Part B)*** (END)
- ◯ Other ***(Please provide location in next question)*** (Go to #15)

15. Please provide location (if applicable):
(Complete Part D Coverage Determination Criteria section below) (Go to #19)

Intramuscular (IM) administration

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

- ◯ Yes ***(Bill to Medicare Part B)*** (END)
- ◯ No (Go to #17)

17. Is the requested product prescribed for a primary immune deficiency disease (including ICD-10 G11.3, D80.0, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D81.0, D81.1, D81.2, D81.5, D81.6, D81.7, D81.82, D81.89, D81.9, D82.0, D82.1, D82.4, D83.0, D83.1, D83.2, D83.8, and D83.9)?

- ◯ Yes ***(Bill to Medicare Part B)*** (Go to #18)
- ◯ No ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #19)

18. Please provide diagnosis/ICD-10 code: (END)

Part D Coverage Determination Criteria (required)

19. Provide primary diagnosis including ICD-10 Code(s): (Go to #20)

20. Are there any other comments, diagnoses, symptoms, medications tried or failed (including dates of drug trials and results of previous drug trials), drug allergies and/or any other pertinent information the physician feels is important to this review? (If yes, please explain below)	◯ Yes (Go to #21)	◯ No (Go to #21)

Exception Requests (optional)

21. If the request is not for a prior authorization, please indicate the request type: (The prescriber MUST provide a statement supporting the request. Requests cannot be processed without one.)

- ☐ N/A - Not an exception request (Go to #28)
- ☐ The member has been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from the list during the plan year. (Go to #22)
- ☐ The request is for an exception to the plan's limit on the number of pills (quantity limit) the member can receive so that the member can get the number of pills the prescriber prescribed. (Go to #22)
- ☐ The drug plan charges a higher copayment for the drug the prescriber prescribed than it charges for another drug that treats the member's condition, and the member wants to pay the lower copayment. (Go to #22)
- ☐ The member has been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier. (Go to #22)
- ☐ The drug plan charged the member a higher copayment for a drug than it should have. (Go to #22)
- ☐ The member wants to be reimbursed for a covered prescription drug that they paid for out of pocket. (Go to #22)

22. Do you believe one or more of the prior authorization requirements should be waived? (If yes, you must provide a statement explaining the medical reason why the exception should be approved.)	○ Yes (Go to #23)	○ No (Go to #23)
23. Would this medication likely be the most effective option for this member? (If yes, please explain below)	○ Yes (Go to #24)	○ No (Go to #24)

24. Is the member currently being treated for the condition(s) requiring the requested drug? (If yes, please explain the member's current drug regimen for the condition(s) below)	◯ Yes (Go to #25)	◯ No (Go to #25)
25. If the member is currently using this medication, would changing the current regimen likely result in adverse effects for the member? (If yes, please explain below)	◯ Yes (Go to #26)	◯ No (Go to #26)
26. Are there any concerns for a drug interaction with the addition of the requested drug to the member's current drug regimen? (If yes, please explain the benefits despite the noted concern and the monitoring plan to ensure safety below)	◯ Yes (Go to #27)	◯ No (Go to #27)
27. Are there any FDA noted contraindications to the requested drug? (If yes, please explain the benefits despite the noted concern and the monitoring plan to ensure safety below)	◯ Yes (Go to #28)	◯ No (Go to #28)

Additional Information

28. Please provide any additional information we should consider (or attach any supporting documents): (END)

Submission Information (required)

Signature: _____ **Date:** _____

Please Note:

- This request may be denied or dismissed unless all required information is received.
- The prescriber's office will receive a response via fax.
- For urgent requests, please call the phone number listed below.
- 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.
- Requests can also be initiated via phone, or the form may be sent via fax or mail:

Phone Number:	(866) 270-3877
Fax Number:	(855) 668-8552
Mailing Address:	ATTN: PRIOR AUTHORIZATION P.O. Box 1039 Appleton, WI 54912-1039

Authorization Period: 1 Year

PLEASE FAX COMPLETED FORM TO: 855-668-8552

This request may be denied or dismissed unless all required information is received. The prescriber`s office will receive a response via fax. For urgent requests, please call the phone number listed below. 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. Requests can also be initiated via phone or the form may be sent via fax or mail: Phone Number: (866) 270-3877, Fax Number: (855) 668-8552, Mailing Address: ATTN: PRIOR AUTHORIZATION, P.O. Box 1039 Appleton, WI 54912-1039.