

PREAUTHORIZATION FORM
 Immunoglobulin, Intravenous

Therapeutic use: An anti-infective, anti-inflammatory and immunomodulatory agent

Quantity Limit: Maximum recommended total dose of 2 gm/kg

Authorization Period: 6 months initially, 12 months for reauthorization

Patient's name _____

Patient's ID# [][][][][][][][][] DOB [][] / [][] / [][][][][]

ICD-9 [][][][][][][][][] _____

Physician's name _____

Physician's Ph# ([][][][]) [][][][] - [][][][][] Fax# [][][][] - [][][][][]

Physician's signature _____ Date signed [][] / [][] / [][][][][]

Supervising Physician's name _____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the patient diagnosed with any of the following disorders? If no, please list diagnosis and include chart notes. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IMMUNOLOGY 1. <input type="checkbox"/> Primary immunodeficiency 2. <input type="checkbox"/> Congenital agammaglobulinemia 3. <input type="checkbox"/> Common variable immunodeficiency 4. <input type="checkbox"/> X-linked immunodeficiency with hyperimmunoglobulin M 5. <input type="checkbox"/> Severe combined immunodeficiency 6. <input type="checkbox"/> Wiskott-Aldrich syndrome 7. <input type="checkbox"/> Specific (qualitative) antibody deficiency syndrome 8. <input type="checkbox"/> Antibody deficiency with normal serum immunoglobulin levels 9. <input type="checkbox"/> Kawasaki Syndrome and <4 years old 10. <input type="checkbox"/> Pediatric human immunodeficiency virus (HIV) with recurrent infection, please list CD4 count: _____ If submitting for criteria 1-8, complete the following questions: • Has the patient had at least one bacterial infection attributed to this deficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No • Is the IgG level <300mg/dL or is there an absence of tetanus or pneumococcal antibody response? <input type="checkbox"/> Yes <input type="checkbox"/> No		DERMATOLOGY 1. <input type="checkbox"/> Clinically confirmed immune mediated blistering disease (pemphigus/pemphigoid), list diagnosis: _____ Please list previously failed therapies: _____ 2. <input type="checkbox"/> Stevens-Johnson syndrome 3. <input type="checkbox"/> Toxic epidermal necrolysis HEMATOLOGY 1. <input type="checkbox"/> Immune mediated thrombocytopenia, please list platelet count: _____ 2. <input type="checkbox"/> Chronic lymphocytic leukemia (CLL) or myeloma with history of severe or life threatening infection and hypogammaglobulinemia 3. <input type="checkbox"/> Allogenic transplant, date: _____ 4. <input type="checkbox"/> Autologous transplant, IgG level: _____ NEUROLOGY 1. <input type="checkbox"/> Chronic inflammatory demyelinating polyneuropathy (CIDP) 2. <input type="checkbox"/> Stiff person syndrome with rigidity of lung and trunk muscles 3. <input type="checkbox"/> Relapsing remitting multiple sclerosis after failure of 2 immunomodulating therapies 4. <input type="checkbox"/> Guillain-Barre syndrome within 2 weeks of onset 5. <input type="checkbox"/> Myasthenia gravis 6. <input type="checkbox"/> Dermatomyositis or polymyositis after failure of IV steroids	
2.	What brand of IVIG is being utilized? _____		
3.	What will be the dose and dosing frequency? _____		
Note: SelectHealth expects that on the initial infusion of IVIG that resuscitative equipment and knowledge of appropriate urgent/emergent protocols be available. This should include at a minimum: epinephrine, IV infusion capabilities, and IV/IM diphenhydramine.			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.