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Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Immune Globulin
Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ Asceniv	☐ Gamastan S/D	☐ Gamunex-C	☐ Privigen
☐ Bivigam	☐ Gammagard	☐ Hizentra	☐ Xembify
☐ Cutaquig	☐ Gammagard S/D	☐ Hyqvia	
☐ Cuvitru	☐ Gammaked	☐ Octagam	
☐ Flebogamma	☐ Gammaplex	☐ Panzyga	

Dose of medication requested _____ mg per kg = _____ g

Frequency and duration of medication requested _____

Please specify dosing schedule. ☐ Scheduled ☐ Intermittent

Member's current actual body weight (ABW) _____ Date _____

Member's current height _____ Date _____

Member's current Body Mass Index (BMI) _____ Date _____

For initiation of intravenous immune globulin (IVIG), if a member's BMI is ≥ 30 kg/m^2 or ABW is > 120% of ideal body weight (IBW), dosing calculated using adjusted body weight has been demonstrated to have similar clinical effect as using ABW. MassHealth suggests the use of this dosing strategy to promote cost effective care. This is not meant to replace clinical decision making when initiating medication therapy. Please complete the below question.

If member meets the criteria noted above (BMI ≥ 30 kg/m^2 or ABW > 120% of IBW), is the member a candidate for adjusted body weight dosing? If criteria are not applicable, this may be left blank.

☐ Yes. MassHealth to calculate total dose based on adjusted body weight* (may round dose to vial size).

☐ No. Please explain why adjusted body weight* dosing is not appropriate for this member. _____

_____

** Adjusted Body Weight = IBW + 0.4 (ABW - IBW)*

Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient

For hospital outpatient billing, provide department-specific facility NPI _____

Drug NDC (if known) or service code _____

Is the member stabilized on the requested medication?

☐ Yes. Please provide start date. _____ ☐ No

Section I. Please specify the indication for all requests except for a diagnosis of dermatomyositis (DM). For Asceniv requests, please also complete Section III as appropriate.

☐ Primary immunodeficiency disorders (PID)

Please attach laboratory documentation supporting diagnosis.

Provide date and results of most recent serum immunoglobulin levels (including laboratory reference ranges).

_____

_____

☐ Immune thrombocytopenia (ITP)

Provide date and results of most recent platelet count (including laboratory reference ranges).

_____

Does the member have clinically significant bleeding? ☐ Yes. Please describe below. ☐ No

_____

Does the member have a history of or risk of significant bleeding? ☐ Yes. Please describe below. ☐ No

_____

Does the member have a medical necessity to raise platelet count within 12 to 24 hours?

☐ Yes. Please describe below. ☐ No

_____

☐ Kawasaki disease (mucocutaneous lymph node syndrome)

Provide date of onset. _____

Does the member have an unexplained persistent fever? ☐ Yes ☐ No

Does the member have evidence of aneurysm? ☐ Yes ☐ No

Does the member exhibit signs of persistent inflammation? ☐ Yes ☐ No

☐ B-cell chronic lymphocytic leukemia (CLL)

☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)

☐ Multifocal motor neuropathy (MMN)

☐ Other _____

Please describe the medical necessity for the use of immune globulin including previous trials and outcomes.

_____

_____

Section II. Please complete for treatment of dermatomyositis (DM). For Asceniv requests, please also complete Section III as appropriate.

1. Has the member had a trial with one systemic corticosteroid?

   ☐ Yes. Please list the dates/duration of trials and outcomes.* Dates/duration of trial _____

   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

   Briefly describe details of adverse reaction, inadequate response, or other.

   _____

   ☐ No. Please explain if there is a contraindication. _____

2. Does the member have severe disease? ☐ Yes ☐ No

over

3. Has the member had a trial with one of the following: azathioprine, chloroquine, hydroxychloroquine, methotrexate, mycophenolate mofetil, or rituximab?
   ☐ Yes. Please list the drug names, dates/duration of trials and outcomes below.*
   Drug name _____ Dates/duration of trial _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain if there is a contraindication to these trials. _____

Section III. Please also complete for requests for Asceniv. Please complete Section I or II above as appropriate.

Please provide clinical rationale for the use of this product instead of other available IVIG products.

_____

_____

Section IV. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____
NPI* _____ Individual MH Provider ID _____
DEA No. _____ Office Contact Name _____
Address _____ City _____ State _____ Zip _____
E-mail address _____
Telephone No.* _____ Fax No.* _____
* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____