15 Earhart Drive, Suite 101, Amherst, NY 14221

# IMMUNE GLOBULIN (IVIG) AUTHORIZATION AND RE-AUTHORIZATION REQUEST

**TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360**

| | | | |
|---|---|---|---|
| Member Name: | Today's Date: | Date Needed: | |
| Date of birth: Sex: Weight: | | Prescriber: | Hospital/Clinic: |
| Home Phone Number: | | Phone Number: | Fax Number: |
| Home Address: City: State: Zip: | | Address: City: State: Zip: | |
| Member's Insurance ID: | | Notes: | |
| Allergies: | | | |

☐ New Authorization ☐ Reauthorization

Drug Name: _____

Dose: _____

Frequency: _____

ICD 10 Code: _____

Expected duration of therapy: _____

☐ Patient's plasma IgG level is 2-3 standard deviations outside the mean for age.

☐ Patient has an inability to make specific antibodies which has been verified through either natural exposure or vaccine challenge.

☐ Patient does **NOT** have selective IgA deficiencies.

**Please select any of the below criteria that apply to patient:**

Primary humoral immunodeficiency disease in patient who is unable to produce sufficient amounts of IgG antibodies

- ☐ X-linked agammaglobulinemia
- ☐ Common variable immunodeficiency
- ☐ Immunoglobulin subclass deficiency
- ☐ X-linked immunodeficiency with hyper-IgM
- ☐ Combined immunodeficiency including Wiskott-Aldrich syndrome
- ☐ Other: _____

***Please provide clinical notes and rationale for use.***

**For Reauthorization, please submit documentation for the following:**

- IgG response *(Please attach)*
- Platelet count response *(Please attach)*
- Number of infection episodes or syndromes: _____

_____

_____

- Adverse Effects (ie. Anaphylaxis, Transient Renal Insufficiency, Severe Hypotension): _____

_____

_____

- Compliance with therapy: _____

_____

_____