



Prescription Drug Coverage Determination Form

IVIG

Gammagard, Gamunex® (intravenous immune globulin)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: _____ Date of Birth: _____
Subscriber ID#: _____
Address _____ City _____ State _____ Zip Code _____

Physician Information

Name: _____ Specialty: _____ Tax ID#: _____
Office Address _____ City _____ State _____ Zip Code _____
Telephone: _____ Fax: _____ Contact Person _____

Physician Signature (REQUIRED): _____ Date _____

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: _____ J-code: _____
Dose: _____ Directions: _____
Expected Duration of Therapy: _____

Prior Authorization Criteria:

- 1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D? Yes No
Diagnosis: _____ ICD-9 code _____
- 2. Is the patient status post HSCT/BMT? Yes No
If yes:
 - Has the patient developed severe hypogammaglobulinemia (IgG less than 400) within the first 100 days post transplant? Yes No
 - Is the patient 20 years of age or older? Yes No
- 3. Does the patient have a diagnosis of Kawasaki disease? Yes No
If yes:
 - Will the IVIG be used in conjunction with high dose aspirin? Yes No
- 4. Does the patient have a diagnosis of dermatomyositis? Yes No
If yes:
 - Has the patient had a trial of or a contraindication to corticosteroid therapy? Yes No
- 5. Does the patient have a diagnosis of Guillain-Barré syndrome? Yes No
If yes:

<ul style="list-style-type: none"> ▪ Does the patient require aid to walk within 2 to 4 weeks after the onset of neuropathic symptoms? 	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the patient have a diagnosis of hyperimmunoglobulinemia E syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
<ul style="list-style-type: none"> ▪ Does the patient have a coincidental diagnosis of eczema and atopic dermatitis? 	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does the patient have a diagnosis of relapsed, remittent multiple sclerosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
<ul style="list-style-type: none"> ▪ Has the patient tried and failed 1st line treatment therapies? 	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Does the patient have a diagnosis of HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
<ul style="list-style-type: none"> ▪ Is the patient less than 13 years of age? 	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.