

## Sterling Retiree Rx Prior Authorization Form

### INTRAVENOUS IMMUNOGLOBULIN (IVIG)

#### Coverage Criteria / Required Medical Information

**PID:** history of infections with nonsustained response to antimicrobial therapy **and** evidence of failed antibody development to established norms for vaccine stimulation.

**CIDP:** presence of objective findings consistent with diagnosis. **Diagnosis by a neurologist.**

**B-Cell CLL:** history of recurrent bacterial infections.

#### Exclusion Criteria

IgA deficiency with antibody formation. Intolerance to any of the components of immune globulin. Presence of risk factor for acute renal failure, unless the patient will receive IGIV products at the minimum concentration available and at the minimum rate of infusion practicable.

**Billable to Part B if patient is in home setting.**

### Member Information

<b>Name</b>					
<b>Enrollment/Card-holder ID Number</b>					
<b>Group/Plan</b>		<b>Male</b>		<b>Female</b>	
<b>Date of Birth</b>		<b>Age</b>		<b>Weight in Kg</b>	
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	

### Physician Information

<b>Name</b>					
<b>Agent</b>		<b>Contact Name</b>			
<b>Specialty/Office</b>					
<b>Clinic Name</b>					
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>Phone</b>		<b>Fax</b>			

### Requested Drug

	<b>Reason for Request</b>	
<b>Condition/Diagnosis Related</b>		

### Clinical Drug/Lab History Pertinent to Request

<b>Labs: Baseline/Ongoing</b>	<b>Strength/Dosage</b>		
<b>Formulary Alternative(s) Attempted?</b>	<b>Yes:</b>		<b>No:</b>
<b>Please List Alternative Formulary Drugs</b>			

<b>Comments</b>	
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Physician Signature: \_\_\_\_\_

**Fax Form to 1-866-481-3704**