health information designs

Immune Globulins
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an immune globulin must meet the following criteria:

- **If patient's BMI > 30, adjusted body weight must be provided along with the calculated dose.**
- **For Gammagard S/D:** Patient must be intolerant to IgA.
- **For Hizentra, Cuvitru, or Hyqvia:** Patient must be unable to tolerate IV administration and fail a trial of two of the following: Gamunex-C, Gammaked, or Gammagard.
- **For all other agents:** Patient must try and fail two of the following: Gamunex-C, Privigen, or Gammagard.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: **Indication for this request:**	**Is patient BMI over 30? □ YES □ NO** **If yes, provide adjusted body weight and calculated dose:** **Is patient intolerant to IgA (i.e., treatment of an autoimmune process in a patient with undetectable levels of IgA)? □YES □NO** **Is patient unable to tolerate IV administration? □ YES □ NO** **Please list all medications patient has tried and failed:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #