Prescriber Criteria Form

IVIG BDC 2026 PA Fax 119-A v2 010126.docx
Intravenous Immune Globulin (Human) – IVIG
Alyglo (intravenous immune globulin human-stwk), Asceniv, Bivigam, Flebogamma Dif, Gammagard Liquid ERC, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, Privigen (intravenous immune globulin), Qivigy (intravenous immune globulin human-kthm), Yimmugo (intravenous immune globulin human-dira)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Intravenous Immune Globulin (Human) – IVIG.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

B vs D CRITERIA FOR DETERMINATION

1	Will the patient be receiving the medication in the home? [If no, then skip to question 5.]	Yes	No
2	Is the patient receiving the requested medication for the diagnosis of primary immune deficiency disease for one of the following ICD-10 codes D80.0, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D83.0, D83.1, D83.2, D83.8, D83.9, D82.0, D82.1, D82.4, D81.0, D81.1, D81.2, D81.5, D81.6, D81.7, D81.89, D81.9, G11.3? (Ask for the ICD-10 codes to determine if the answer is yes or no.) [If yes, then no further questions.] Tech Note: Medicare Part B pays for these ICD-10 codes when used in the home D80.0 Hereditary hypogammaglobulinemia D80.2 Selective deficiency of immunoglobulin A [IgA] D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses	Yes	No

	D80.4	Selective deficiency of immunoglobulin M [IgM]		
	D80.5	Immunodeficiency with increased immunoglobulin M [IgM]		
	D80.6	Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia		
	D80.7	Transient hypogammaglobulinemia of infancy		
	D83.0	Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function		
	D83.1	Common variable immunodeficiency with predominant immunoregulatory T-cell disorders		
	D83.2	Common variable immunodeficiency with autoantibodies to B- or T-cells		
	D83.8	Other common variable immunodeficiencies		
	D83.9	Common variable immunodeficiency, unspecified		
	D82.0	Wiskott-Aldrich syndrome		
	D82.1	Di George's syndrome		
	D82.4	Hyperimmunoglobulin E [IgE] syndrome		
	D81.0	Severe combined immunodeficiency [SCID] with reticular dysgenesis		
	D81.1	Severe combined immunodeficiency [SCID] with low T- and B-cell numbers		
	D81.2	Severe combined immunodeficiency [SCID] with low or normal B-cell numbers		
	D81.5	Purine nucleoside phosphorylase [PNP] deficiency		
	D81.6	Major histocompatibility complex class I deficiency		
	D81.7	Major histocompatibility complex class II deficiency		
	D81.89	Other combined immunodeficiencies		
	D81.9	Combined immunodeficiency, unspecified		

	G11.3 Cerebellar ataxia with defective DNA repair		
3	Is this a request for Gamunex-C, Gammaked, or Gammagard and is the requested drug being administered subcutaneously? [If no, then skip to question 9.]	Yes	No
4	Is the patient receiving the requested medication for the diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS) (ICD-10 code D81.82)? [If yes, then no further questions.] [If no, then skip to question 9.]	Yes	No
5	Will the patient be receiving the medication in a medical office or infusion center? [If no, then skip to question 7.]	Yes	No
6	Is the requested drug being supplied from the practitioner and/or office stock supply and billed as part of a practitioner service (i.e., the drug is being furnished "incident to a practitioner's service")? [If yes, then no further questions.] [If no, then skip to question 9.]	Yes	No
7	[The answer to the following question is NO if the patient resides in his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution such as an assisted living facility, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID).] Does the patient reside in one of the following skilled nursing facilities (SNF)/skilled care facilities: A) a nursing home that is dually-certified as both a Medicare SNF and a Medicaid nursing facility (NF), B) a Medicaid-only NF that primarily furnishes skilled care, C) a non-participating nursing home (i.e., neither Medicare nor Medicaid) that provides primarily skilled care, D) an institution which has a distinct part SNF and which also primarily furnishes skilled care? [If no, then skip to question 9.]	Yes	No
8	Is Medicare Part A paying for the long-term care (LTC) facility bed during the days this treatment is being requested? [If yes, then no further questions.]	Yes	No
CRITERIA FOR APPROVAL			
9	Does the patient have a diagnosis of primary immunodeficiency? [If yes, then no further questions.]	Yes	No
10	Does the patient have a diagnosis of idiopathic thrombocytopenic purpura (ITP)? [If yes, then no further questions.]	Yes	No
11	Does the patient have a diagnosis of Kawasaki syndrome? [If yes, then no further questions.]	Yes	No

12	Does the patient have a diagnosis of B-cell chronic lymphocytic leukemia (CLL)? [If no, then skip to question 14.]	Yes	No
13	Does the patient have a serum immunoglobulin G (IgG) level less than 500 milligrams per deciliter OR a history of recurrent bacterial infections? [No further questions.]	Yes	No
14	Does the patient have a diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP)? [If yes, then no further questions.]	Yes	No
15	Does the patient have a diagnosis of multifocal motor neuropathy (MMN)? [If yes, then no further questions.]	Yes	No
16	Does the patient have a diagnosis of pure red cell aplasia (PRCA) secondary to parvovirus B19 infection? [If yes, then no further questions.]	Yes	No
17	Does the patient have a diagnosis of myasthenia gravis? [If yes, then no further questions.]	Yes	No
18	Does the patient have a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS)? [If yes, then no further questions.]	Yes	No
19	Does the patient have a diagnosis of fetal/neonatal alloimmune thrombocytopenia (F/NAIT)? [If yes, then no further questions.]	Yes	No
20	Is the patient a bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipient? [If no, then skip to question 23.]	Yes	No
21	Is the medication being requested within the first 100 days post-transplant? [If yes, then no further questions.]	Yes	No
22	Is the patient's serum immunoglobulin G (IgG) level less than 400 milligrams per deciliter? [No further questions.]	Yes	No
23	Does the patient have a diagnosis of pediatric human immunodeficiency virus (HIV) infection? [If no, then skip to question 26.]	Yes	No
24	Is the patient's serum immunoglobulin G (IgG) level less than 400 milligrams per deciliter? [If yes, then no further questions.]	Yes	No
25	Does the patient have a history of recurrent bacterial infections? [No further questions.]	Yes	No
26	Does the patient have a diagnosis of Guillain-Barre syndrome (GBS)? [If yes, then no further questions.]	Yes	No

27	Does the patient have a diagnosis of dermatomyositis? [If yes, then skip to question 29.]	Yes	No
28	Does the patient have a diagnosis of polymyositis? [If no, then skip to question 30.]	Yes	No
29	Are either of the following statements true: A) at least one standard first-line treatment (corticosteroid or immunosuppressant) has been tried but was unsuccessful or not tolerated, B) patient is unable to receive standard therapy because of a contraindication or other clinical reason? [No further questions.]	Yes	No
30	Does the patient have a diagnosis of stiff-person syndrome?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____