



State of Oklahoma
SoonerCare

Immune Globulin (IG) Intravenous (IV) & Subcutaneous (SC) Products
Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Physician billing (HCPCS code: _____) Pharmacy billing (NDC: _____)

Dose: _____ Regimen: _____ Start Date (or date of next dose): _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization:

1. Documentation of prior stabilization on the requested product with documented benefit from therapy (i.e., recent office notes) must be submitted with the request. Is this information attached? Yes ___ No ___
2. Member's recent weight: _____(kg); Date obtained: _____
3. For Alyglo™, Qivigy® and Asceniv™, please provide a patient-specific, clinically significant reason why the member cannot use all other available immunoglobulin therapy products: _____
4. For intravenous (IV) administration, please provide a patient-specific, clinically significant reason why the member cannot use all of the following, which are available without prior authorization: Gammagard Liquid®, Gammagard S/D®, Gammaked™, Gamunex®-C, Privigen®: _____
5. For subcutaneous (SC) administration, please provide a patient-specific, clinically significant reason why the member cannot use all of the following, which are available without prior authorization: Cutaquig®, Hyqvia®, Gammagard Liquid®, Gammaked™, Gamunex®-C: _____

For Continued Authorization:

1. Date of last dose: _____
2. Member's weight: _____(kg); Date taken: _____
3. Please provide documentation of clinical effectiveness: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

<p>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p>CONFIDENTIALITY NOTICE</p> <p>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</p>
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