

Immune Globulin (IVIG and SCIG) Prior Authorization Form

Please complete this form for UnitedHealthcare members needing an Immune Globulin prescription.

Fax the completed form to UnitedHealthcare at 877-310-3826.

UnitedHealthcare will notify you and your patient of prescription approval.

This form helps UnitedHealthcare determine if the patient's condition meets our drug policy guidelines.

Please fill out the form completely. Any missing information may cause a delay in the approval.

Fax: **877-310-3826** | Phone: **800-366-7304**

Patient Information	
Patient's Name: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Insurance ID: _____	Date of Birth: _____
Address: _____	Weight: _____
City: _____	Apartment #: _____
State: _____	Zip Code: _____
Phone Number: _____	Alternate Phone Number: _____

Please attach the front and back side of the member's insurance card.

Prescriber Information	
Name: _____	Tax ID: _____
Address: _____	Suite #: _____
City: _____	State: _____
Phone Number: _____	Zip Code: _____
Fax Number: _____	
Office Contact: _____	Contact Phone / Extension: _____

Diagnosis Information	
Please attach clinical information supporting stated diagnosis, including medication(s) previously tried and failed, and laboratory reports. Reference drug policy for diagnosis specific requirements at uhcommunityplan.com	
<input type="checkbox"/> C91.10 – Chronic lymphocytic leukemia of B-cell type not having achieved remission	<input type="checkbox"/> G35 – Multiple Sclerosis
<input type="checkbox"/> D69.3 – Immune thrombocytopenic purpura	<input type="checkbox"/> G40.81 – Lennox-Gastaut syndrome
<input type="checkbox"/> D80.0 – Hereditary hypogammaglobulinemia	<input type="checkbox"/> G61.0 – Guillain-Barre syndrome
<input type="checkbox"/> D80.1 – Nonfamilial hypogammaglobulinemia	<input type="checkbox"/> G61.81 – Chronic inflammatory demyelinating polyneuritis
<input type="checkbox"/> D81.2 – Severe combined immunodeficiency [SCID] with low or normal B-cell numbers	<input type="checkbox"/> G70.01 – Myasthenia gravis with (acute) exacerbation
<input type="checkbox"/> D83.0 – Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function	<input type="checkbox"/> G70.81 – Lambert-Eaton syndrome in disease classified elsewhere
<input type="checkbox"/> D83.8 – Other common variable immunodeficiencies	<input type="checkbox"/> M33.22 – Polymyositis with myopathy
<input type="checkbox"/> D89.9 – Disorder involving the immune mechanism, unspecified	<input type="checkbox"/> M33.99 – Dermatopolymyositis, unspecified with other organ involvement
<input type="checkbox"/> G25.82 – Stiff-man syndrome	<input type="checkbox"/> Other _____

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Clinical Information

Is the patient new to therapy: Yes, requested start date: _____ No

If no, provide the following: Start date: _____ Date of last dose: _____

Will the physician supply the medication?: Yes No

If no, who will supply the medication?: _____

Site of care: Infusion Center Physician's Office Self-Administration

Home Health with Nursing (Name, Address, City, State, Zip) _____

Duration of treatment: _____

Medication Information

Medication: _____ J Code / CPT Code: _____ Dose: _____

Directions: _____

Quantity: _____ Refills: _____ Duration of Treatment: _____

Physician Signature: _____

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