Immune Globulin (IVIG and SCIG) Prior Authorization Form

UnitedHealthcare Community Plan

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: ☐ M ☐ F

Insurance ID: _____ Date of Birth: _____ Weight: _____

Address: _____ Apartment #: _____

City: _____ 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: _____ Zip Code: _____

Phone Number: _____ 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 uhccommunityplan.com

- ☐ C91.10 – Chronic lymphocytic leukemia of B-cell type not having achieved remission
- ☐ D69.3 – Immune thrombocytopenic purpura
- ☐ D80.0 – Hereditary hypogammaglobulinemia
- ☐ D80.1 – Nonfamilial hypogammaglobulinemia
- ☐ D81.2 – Severe combined immunodeficiency [SCID] with low or normal B-cell numbers
- ☐ D83.0 – Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function
- ☐ D83.8 – Other common variable immunodeficiencies
- ☐ D89.9 – Disorder involving the immune mechanism, unspecified
- ☐ G25.82 – Stiff-man syndrome
- ☐ G35 – Multiple Sclerosis
- ☐ G40.81 – Lennox-Gastaut syndrome
- ☐ G61.0 – Guillain-Barre syndrome
- ☐ G61.81 – Chronic inflammatory demyelinating polyneuritis
- ☐ G70.01 – Myasthenia gravis with (acute) exacerbation
- ☐ G70.81 – Lambert-Eaton syndrome in disease classified elsewhere
- ☐ M33.22 – Polymyositis with myopathy
- ☐ M33.99 – Dermatopolymyositis, unspecified with other organ involvement
- ☐ 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: _____