



**BlueCross
BlueShield**

Federal Employee Program

**SCIG IMMUNE GLOBULIN
PRIOR APPROVAL REQUEST**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn: Clinical Services
Fax: 1-877-378-4727

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R <input type="text"/>			Physician Signature:		
PHYSICIAN COMPLETES						

SCIG Immune Globulin (subcutaneous immunoglobulin)

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

☐ Cutaquig ☐ Cuvitru ☐ Hizentra ☐ Hyqvia ☐ Xembify

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

- Has the patient been on this medication continuously for the last **6 months**, excluding samples? **Select answer below:**
 - ☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
 - ☐ **NO** – this is **INITIATION** of therapy, please answer the following questions:
- Is this request for brand or generic? ☐ Brand ☐ Generic
- Has the patient or their caregiver been instructed on how to monitor for signs and symptoms of thrombosis when self-administering the medication? ☐ Yes ☐ No
- Will this medication be given with other immune globulin medications? ☐ Yes* ☐ No
***If YES**, specify other medication(s): _____
- What is the patient's diagnosis?
 - ☐ **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) (Hizentra OR Hyqvia Request)**
 - Has the patient been treated previously with immunoglobulin therapy (IVIG)? ☐ Yes ☐ No
 - Hizentra only:** Will Hizentra be initiated one week after the last infusion of IVIG? ☐ Yes ☐ No
 - Hyqvia only:** Does the prescriber agree to initiate Hyqvia two weeks after the last infusion of IVIG? ☐ Yes ☐ No
 - Has the patient had significant improvement in disability and has maintained improvement while on previous IVIG? ☐ Yes ☐ No
 - ☐ **Primary Immunodeficiency Disease (PID): Please select the subtype below:**
 - ☐ **Agammaglobulinemia**
 - Has the patient's diagnosis been confirmed by genetic or molecular testing? ☐ Yes ☐ No
 - Does the patient have a pretreatment IgG level less than 200mg/dL? ☐ Yes ☐ No
 - ☐ **Ataxia-telangiectasia OR DiGeorge syndrome OR Wiskott-Aldrich syndrome**
 - Has the patient's diagnosis been confirmed by genetic or molecular testing? ☐ Yes ☐ No
 - Does the patient have a documented history of recurrent bacterial and viral infections? ☐ Yes ☐ No
 - Does the patient have an impaired antibody response to the pneumococcal vaccine? ☐ Yes ☐ No
 - ☐ **Common Variable Immunodeficiency Disease (CVID)**
 - Does the patient have a documented history of recurrent bacterial and viral infections? ☐ Yes ☐ No
 - Does the patient have an impaired antibody response to the pneumococcal vaccine? ☐ Yes ☐ No
 - Have other causes of immune deficiency been excluded including: drug-induced, genetic disorders, infectious diseases such as HIV, or malignancy? ☐ Yes ☐ No
 - Does the patient have a pre-treatment IgG level of less than 500mg/dL? ☐ Yes ☐ No*
***If NO**, does the patient have a pre-treatment IgG equivalent to 2 or more standard deviations below the mean for the age of the patient? ☐ Yes ☐ No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

PAGE 1 of 3

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. SCIG – FEP MD Fax Form Revised 5/16/2025



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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

☐ Primary Immunodeficiency Disease (PID): *Please select the subtype below:*

☐ Hypogammaglobulinemia

a. Does the patient have a pre-treatment IgG level of less than 500mg/dL? ☐ Yes ☐ No*

**If NO*, does the patient have a pre-treatment IgG equivalent to 2 or more standard deviations below the mean for the patient's age? ☐ Yes ☐ No

b. Does the patient have a documented history of recurrent bacterial and viral infections? ☐ Yes ☐ No

c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ☐ Yes ☐ No

☐ IgG subclass deficiency

a. Does the patient have a pre-treatment IgG1, IgG2, or IgG3 equivalent to 2 or more standard deviations below the mean for the patient's age on at least two separate occasions? ☐ Yes ☐ No

b. Does the patient have IgG (total) and IgM levels within normal limits? ☐ Yes ☐ No

c. Does the patient have IgA levels within low to normal limits? ☐ Yes ☐ No

d. Does the patient have a documented history of recurrent bacterial and viral infections? ☐ Yes ☐ No

e. Does the patient have an impaired antibody response to the pneumococcal vaccine? ☐ Yes ☐ No

☐ Selective IgA deficiency

a. Does the patient have a pre-treatment IgA level of less than 7mg/dL? ☐ Yes* ☐ No

**If YES*, does the patient have IgG and IgM levels within normal limits? ☐ Yes ☐ No

b. Does the patient have a documented history of recurrent bacterial and viral infections? ☐ Yes ☐ No

c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ☐ Yes ☐ No

☐ Selective IgM deficiency

a. Does the patient have a pre-treatment IgM level of less than 30mg/dL? ☐ Yes* ☐ No

**If YES*, does the patient have IgG and IgA levels within normal limits? ☐ Yes ☐ No

b. Does the patient have a documented history of recurrent bacterial and viral infections? ☐ Yes ☐ No

c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ☐ Yes ☐ No

☐ Severe Combined Immunodeficiency Disease (SCID)

a. Does the patient have an absence or very low number of T cells (CD3 T cells less than 300/microliter)? ☐ Yes ☐ No*

**If NO*, is there a presence of maternal T cells in the circulation? ☐ Yes ☐ No

b. Does the patient have a confirmed diagnosis by genetic or molecular testing? ☐ Yes ☐ No

c. Does the patient have a pre-treatment IgG less than 200mg/dL? ☐ Yes ☐ No

☐ Other non-SCID combined immunodeficiency (*please specify*): _____

a. Has the patient's diagnosis been confirmed by genetic or molecular testing? ☐ Yes ☐ No

b. Does the patient have a documented history of recurrent bacterial and viral infections? ☐ Yes ☐ No

c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ☐ Yes ☐ No

☐ Specific antibody deficiency

a. Does the patient have IgA, IgG, and IgM levels within normal limits? ☐ Yes ☐ No

b. Does the patient have a documented history of recurrent bacterial and viral infections? ☐ Yes ☐ No

c. Does the patient have an impaired antibody response to the pneumococcal vaccine? ☐ Yes ☐ No

☐ Other diagnosis (*please specify*): _____

PAGE 2 of 3



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Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R			Physician Signature:		
PHYSICIAN COMPLETES						

**CONTINUATION OF THERAPY (PA RENEWAL)
SCIG Immune Globulin (subcutaneous immunoglobulin)**

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

☐ Cutaquig ☐ Cuvitru ☐ Hizentra ☐ Hyqvia ☐ Xembify

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

- Has the patient been on this medication continuously for the last **6 months**, excluding samples? **Select answer below:**
 - ☐ **NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
 - ☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
- Is this request for brand or generic? ☐ Brand ☐ Generic
- What is the patient's diagnosis?
 - ☐ **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) (Hizentra Request OR Hyqvia Request)**
 - Have the CIDP symptoms remained stable or improved since changing from previous immunoglobulin therapy (intravenous immunoglobulin)? ☐ Yes ☐ No
 - ☐ **Primary Immunodeficiency Disease (PID)**
 - Will the patient's IgG trough levels be monitored at least yearly and maintained at or above the lower range of normal for the patient's age? ☐ Yes ☐ No
 - Has the patient had a documented reduction in frequency of bacterial and viral infections since starting this medication? ☐ Yes ☐ No
 - Which type of primary immunodeficiency disease does the patient have? **Please select the PID below:**

<input type="checkbox"/> Agammaglobulinemia	<input type="checkbox"/> Ataxia-telangiectasia	<input type="checkbox"/> Common Variable Immunodeficiency Disease (CVID)
<input type="checkbox"/> DiGeorge syndrome	<input type="checkbox"/> Hypogammaglobulinemia	<input type="checkbox"/> IgG subclass deficiency
<input type="checkbox"/> Selective IgA deficiency	<input type="checkbox"/> Selective IgM deficiency	<input type="checkbox"/> Severe Combined Immunodeficiency Disease (SCID)
<input type="checkbox"/> Specific antibody deficiency	<input type="checkbox"/> Wiskott-Aldrich syndrome	
<input type="checkbox"/> Other non-SCID combined immunodeficiency (<i>please specify</i>): _____		
<input type="checkbox"/> Other immune deficiency (<i>please specify</i>): _____		
 - ☐ Other diagnosis (*please specify*): _____
- Will the prescriber re-evaluate the dose of the medication and reconsider a dose adjustment as needed? ☐ Yes ☐ No
- Has the patient or their caregiver been instructed on how to monitor for signs and symptoms of thrombosis when self-administering the medication? ☐ Yes ☐ No
- Will this medication be given with other immune globulin medications? ☐ Yes* ☐ No

***If YES, specify other medication(s):** _____

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