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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			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**

1. 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:
2. Is this request for brand or generic? ❑ Brand ❑ Generic
3. 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
4. Will this medication be given with other immune globulin medications? ❑Yes* ❑No
   ****If YES***, specify other medication(s): _____
5. What is the patient's diagnosis?
   ❑Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) **(Hizentra OR Hyqvia Request)**
   a. Has the patient been treated previously with immunoglobulin therapy (IVIG)? ❑Yes ❑No
   b. **Hizentra only**: Will Hizentra be initiated one week after the last infusion of IVIG? ❑Yes ❑No
   c. **Hyqvia only**: Does the prescriber agree to initiate Hyqvia two weeks after the last infusion of IVIG? ❑Yes ❑No
   d. 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
   a. Has the patient's diagnosis been confirmed by genetic or molecular testing? ❑Yes ❑No
   b. Does the patient have a pretreatment lgG level less than 200mg/dL? ❑Yes ❑No

   ❑ Ataxia-telangiectasia **OR** ❑DiGeorge syndrome **OR** ❑Wiskott-Aldrich syndrome
   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

   ❑Common Variable Immunodeficiency Disease (CVID)
   a. Does the patient have a documented history of recurrent bacterial and viral infections? ❑Yes ❑No
   b. Does the patient have an impaired antibody response to the pneumococcal vaccine? ❑Yes ❑No
   c. Have other causes of immune deficiency been excluded including: drug-induced, genetic disorders, infectious diseases such as HIV, or malignancy? ❑Yes ❑No
   d. Does the patient have a pre-treatment lgG level of less than 500mg/dL? ❑Yes ❑No*
      ****If NO***, does the patient have a pre-treatment lgG 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

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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 lgG level of less than 500mg/dL? ❑Yes ❑No*****

****If NO***, does the patient have a pre-treatment lgG 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

❑lgG subclass deficiency

a. Does the patient have a pre-treatment lgG1, lgG2, or lgG3 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 lgG (total) and lgM levels within normal limits? ❑Yes ❑No

c. Does the patient have lgA 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 lgA deficiency

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

****If YES***, does the patient have lgG and lgM 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 lgM deficiency

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

****If YES***, does the patient have lgG and lgA 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 lgG 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 lgA, lgG, and lgM 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)***: _____

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Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑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**

1. 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:
2. Is this request for brand or generic? ❑ Brand ❑ Generic
3. What is the patient's diagnosis?
   - ❑ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) **(Hizentra Request OR Hyqvia Request)**
     a. Have the CIDP symptoms remained stable or improved since changing from previous immunoglobulin therapy (intravenous immunoglobulin)? ❑Yes ❑No
   - ❑ Primary Immunodeficiency Disease (PID)
     a. 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
     b. Has the patient had a documented reduction in frequency of bacterial and viral infections since starting this medication? ❑Yes ❑No
     c. Which type of primary immunodeficiency disease does the patient have? ***Please select the PID below:***

❑Agammaglobulinemia	❑Ataxia-telangiectasia	❑Common Variable Immunodeficiency Disease (CVID)
❑DiGeorge syndrome	❑Hypogammaglobulinemia	❑IgG subclass deficiency
❑Selective lgA deficiency	❑Selective lgM deficiency	❑Severe Combined Immunodeficiency Disease (SCID)
❑Specific antibody deficiency	❑Wiskott-Aldrich syndrome	

     ❑Other non-SCID combined immunodeficiency ***(please specify)***: _____
     ❑Other immune deficiency ***(please specify)***: _____
   - ❑ Other diagnosis ***(please specify):*** _____
4. Will the prescriber re-evaluate the dose of the medication and reconsider a dose adjustment as needed? ❑Yes ❑No
5. 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
6. Will this medication be given with other immune globulin medications? ❑Yes* ❑No
   ****If YES***, specify other medication(s): _____