CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Intravenous Immune Globulin (IVIG)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of **Blue Cross Blue Shield of RI** Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): ☐ _____ • Date of Diagnosis: _____

Preferred IVIG:
- ☐ Gamunex-C

Non-Preferred IVIG:
- ☐ Carimune NF
- ☐ Flebogamma DIF
- ☐ Gammagard S/D
- ☐ Gammagard Liquid
- ☐ Gammaplex
- ☐ Octagam
- ☐ Privigen

Non-Preferred IVIG products require a trial of Gamunex/Gamunex-C

Check applicable boxes:

- Patient has IgA deficiency and tested positive for anti-IgA antibodies? ☐ Yes ☐ No
- If yes, is Flebogamma DIF or Gammagard S/D the requested IVIG product? ☐ Yes ☐ No
- Has the patient experienced a hypersensitivity or infusion reaction with Gamunex/Gamunex-C? ☐ Yes ☐ No
- If yes, please describe the adverse event: _____
- Did the adverse event resolve by slowing the infusion rate? ☐ Yes ☐ No
- Did the adverse event require other supportive treatment (eg, stopping the infusion)? ☐ Yes ☐ No

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

IVIG may be approved for any of the following indications:

- Hypogammaglobulinemia ☐ Yes ☐ No
- Congenital agammaglobulinemia (X-linked agammaglobulinemia) ☐ Yes ☐ No
- Common variable immunodeficiency ☐ Yes ☐ No
- X-linked immunodeficiency with hyperimmunoglobulin M ☐ Yes ☐ No
- Severe combined immunodeficiency ☐ Yes ☐ No
- Wiskott-Aldrich syndrome ☐ Yes ☐ No
- Idiopathic Thrombocytopenic Purpura (ITP) ☐ Yes ☐ No
- Kawasaki Syndrome ☐ Yes ☐ No
- Hypogammaglobulinemia and/or recurrent bacterial infection associated with B-cell chronic lymphocytic leukemia ☐ Yes ☐ No
- Reducing the risk of graft-versus-host disease associated with interstitial pneumonia (infectious or idiopathic) and infectious (cytomegalovirus infections, Varicella-zoster virus infection, and recurrent bacterial infection) in allogeneic bone marrow transplant patients in the first 100 days after transplantation ☐ Yes ☐ No
- Prevention of infection due to HIV infection in a pediatric patient ☐ Yes ☐ No
- Prevention of infection due to a Bone marrow transplant ☐ Yes ☐ No
- Antenatal alloimmune thrombocytopenia ☐ Yes ☐ No
- Autoimmune neutropenia ☐ Yes ☐ No
- Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) ☐ Yes ☐ No
- Dermatomyositis, refractory ☐ Yes ☐ No
- Lambert-Eaton myasthenic syndrome treatment ☐ Yes ☐ No

CONTINUED ON PAGE 2

- Guillain-Barre Syndrome (acute demyelinating polyneuropathy) as an equivalent alternative to plasma exchange ☐ Yes ☐ No
- Hyperimmunoglobulinemia E syndrome (HIE) treatment ☐ Yes ☐ No
- Multi-focal motor neuropathy in patients with anti GM1 antibodies and conduction block ☐ Yes ☐ No
- Multiple sclerosis, relapsing-remitting treatment ☐ Yes ☐ No
- Myasthenia Gravis, severe refractory ☐ Yes ☐ No
- Polymyositis ☐ Yes ☐ No
- Prior to a medically necessary renal transplantation for suppression of panel reactive anti-HLA antibodies in patients with high panel reactive antibody (PRA) levels to human leukocyte antigens (HLA) ☐ Yes ☐ No
- Prevention of infections in high-risk, preterm, low birth weight neonates ☐ Yes ☐ No
- Stiff-person syndrome not controlled by other therapies ☐ Yes ☐ No
- Toxic shock syndrome caused by staphylococcal or streptococcal organisms refractory to several hours of aggressive therapy ☐ Yes ☐ No
- Solid organ transplant recipients at risk for CMV ☐ Yes ☐ No
- Treatment of chronic parvovirus B19 infection and severe anemia associated with bone marrow suppression ☐ Yes ☐ No
- Refractory auto-immune mucocutaneous blistering diseases including: ☐ Yes ☐ No
  - ☐ pemphigus vulgaris
  - ☐ pemphigus foliaceus
  - ☐ bullous pemphigoid
  - ☐ mucous membrane pemphigoid
  - ☐ epidermolysis bullosa acquisita

PLEASE NOTE: IVIG may NOT be approved for treatment of Recurrent Spontaneous Abortion (RSA)

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Gamunex/Gamunex-C 10% Liquid *	☐1g ☐2.5g ☐5g ☐10g ☐20g	Administered: ☐Intravenously (IV) ☐Subcutaneously (SC)		
☐				

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)

*PLEASE NOTE: Gamunex-C for subcutaneous use may be approved for primary immunodeficiency disease only.