Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Immune Globulin
Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ Bivigam	☐ Gamastan S/D	☐ Gamunex-C	☐ Privigen
☐ Carimune NF	☐ Gammagard	☐ Hizentra	
☐ Cutaquig	☐ Gammagard S/D	☐ Hyqvia	
☐ Cuvitru	☐ Gammaked	☐ Octagam	
☐ Flebogamma	☐ Gammaplex	☐ Panzyga	

Dose, frequency, and duration of medication requested _____

Member's current weight _____

Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient

For hospital outpatient billing, provide department-specific facility NPI _____

Drug NDC (if known) or service code _____

Is the member stabilized on the requested medication? ☐ Yes. Please provide start date. _____ ☐ No

Section I. Please specify the indication for all requests for immune globulin.

☐ Primary immunodeficiency disorders (PID)

Provide date and results of most recent serum immunoglobulin levels (including laboratory reference ranges).

_____

_____

☐ Immune thrombocytopenia (ITP)

Provide date and results of most recent platelet count (including laboratory reference ranges).

_____

_____

Is the member actively bleeding? ☐ Yes. Please describe below. ☐ No

_____

Does the member have a history of or risk of significant bleeding? ☐ Yes. Please describe below. ☐ No

_____

☐ Kawasaki disease (mucocutaneous lymph node syndrome)

Provide date of onset. _____

☐ B-cell chronic lymphocytic leukemia (CLL)

☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)

☐ Multifocal motor neuropathy (MMN)

☐ Other _____

Please describe the medical necessity for the use of immune globulin including previous trials and outcomes.

_____

_____

Section II. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____