OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Immune Globulins Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ B-cell chronic lymphocytic leukemia
- ❑ Chronic inflammatory demyelinating polyneuropathy (CIDP)
- ❑ Cytomegalovirus
- ❑ Hepatitis A
- ❑ Hepatitis B, prophylaxis and post-exposure
- ❑ Immunodeficiency
- ❑ Immune thrombocytopenic purpura (ITP)
- ❑ Kawasaki syndrome
- ❑ Kidney transplant rejection, acute
- ❑ Measles
- ❑ Multifocal motor neuropathy
- ❑ Rh hemolytic disease prevention
- ❑ Rubella
- ❑ Varicella
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the patient a new patient who has joined GCHP within the past 90 days? ❑ **Yes** ❑ **No**
Is the use supported by independent review entity? ❑ **Yes** ❑ **No**
Is there presence of contraindications or absolute drug interactions with existing therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

For continuation of existing therapy, also answer the following:

Would sudden discontinuation of the dose trigger withdrawal symptoms? ❑ **Yes** ❑ **No**
Would discontinuation of the dose be unsafe for the patient and their condition may worsen or exacerbate? ❑ **Yes** ❑ **No**
Is the prescribing provider attempting to taper or reduce the dose necessary? ❑ **Yes** ❑ **No**

Immune Globulins Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-297-2870.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.