



Date of Request: \_\_\_\_\_

### Sterling Retiree Rx Prior Authorization Form

#### GAMMAGARD, GAMUNEX

##### Coverage Criteria / Required Medical Information

**Bone Marrow Transplant (BMT)** - IVIG to be used within first 100 days following BMT.

**Dermatomyositis** - IVIG to be used only if corticosteroid is not a therapeutic option.

**Guillain-Barre Syndrome (GBS)** - IVIG is to be used for patients who require aid to walk within 2 or 4 weeks from the onset of neuropathic symptoms. Hyperimmunoglobulinemia E syndrome - diagnosis has to be coincident with eczema and atopic dermatitis.

**Hematopoietic Stem Cell Transplant (HSCT)** – IVIG to be used in patients that have developed severe hypogammaglobulinemia (IgG < 400) within the first 100 days post transplant.

**Hyperimmunoglobulinemia E Syndrome** - diagnosis must be coincident with eczema and atopic dermatitis.

**Kawasaki disease** - IVIG to be used in conjunction with high dose aspirin.

**Relapsing/Remitting Multiple Sclerosis (RRMS)** - IVIG to be used as 2nd line treatment.

##### Exclusion Criteria

Non FDA approved treatment

<b>Name</b>					
<input type="text"/>					
<b>Enrollment/Card-holder ID Number</b>					
<input type="text"/>					
<b>Group/Plan</b>		<b>Male</b>		<b>Female</b>	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
<b>Date of Birth</b>		<b>Age</b>		<b>Weight in Kg</b>	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
<b>Street Address</b>					
<input type="text"/>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<input type="text"/>		<input type="text"/>		<input type="text"/>	

#### Physicians Information

<b>Name</b>					
<input type="text"/>					
<b>Agent</b>			<b>Contact Name</b>		
<input type="text"/>			<input type="text"/>		
<b>Specialty/Office</b>					
<input type="text"/>					
<b>Clinic Name</b>					
<input type="text"/>					
<b>Street Address</b>					
<input type="text"/>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
<b>Phone</b>			<b>Fax</b>		
<input type="text"/>			<input type="text"/>		

#### Requested Drug

<b>IVIG</b>		<b>Reason for Request</b>			
<input type="text"/>		<input type="text"/>			
<b>Condition/Diagnosis Related</b>		<input type="text"/>			

#### Clinical Drug/Lab History Pertinent to Request

<b>Labs: Baseline/Ongoing</b>		<b>Strength/Dosage</b>	
<input type="text"/>		<input type="text"/>	
<b>Please List Alternative Formulary Drugs</b>		<input type="text"/>	
<input type="text"/>		<input type="text"/>	
<input type="text"/>		<input type="text"/>	

<b>Comments</b>	<input type="text"/>
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Physicians Signature: \_\_\_\_\_

Fax Form to 1-877-847-9904