HyQvia

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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Patient's Name: ______________________________ **Date**: __________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** __________________
Physician's Name: ____________________________ **NPI#:** __________________________________
Specialty: __________________________________ **HPHC Provider ID**______________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

Rendering Provider Info: ❑ Same as Requesting Provider **HPHC Provider ID:**______________________
Name: ____ **NPI#:** __________________________________
Fax: _____________________ **Phone:** __________________ **Provider Tax ID:** _________________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Drug Information:

*Strength/Measure*_____________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*________________________________ *Route of administration*________________________
*Dosing frequency*_____________________________

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. HyQvia SGM – 12/2018.

Criteria Questions:

1. What is the diagnosis?
   ❑ Primary immunodeficiency (eg, common variable immunodeficiency, X-linked agammaglobulinemia, severe combined immunodeficiency, Wiskott-Aldrich syndrome)
   ❑ Chronic inflammatory demyelinating polyneuropathy
   ❑ Other ____

2. What is the ICD-10 code? ________________

3. Is this a request for continuation of immune globulin therapy? ❑ Yes ❑ No *If No, skip to #8*

4. Has the patient experienced a reduction in the frequency of bacterial infections since starting immune globulin therapy? ❑ Yes ❑ No

5. Does the prescriber measure trough IgG levels at least once per year?
   ❑ Yes ❑ No ❑ Not applicable for diagnosis

6. Is the most recent trough IgG level at or above the lower range of normal for age? ***ACTION REQUIRED: Attach a copy of the laboratory report with a recent IgG trough level***
   ❑ Yes, *no further questions* ❑ No ❑ Not applicable for diagnosis, *no further questions*

7. Will the prescriber re-evaluate the dose of immune globulin and consider a dose adjustment (when clinically appropriate)? ❑ Yes ❑ No ❑ Not applicable/not clinically appropriate *No further questions*

8. What is the specific immunodeficiency disorder?
   ❑ Severe combined immunodeficiency (SCID), ***specify:*** ____
   ❑ Congenital agammaglobulinemia (eg, X-linked or autosomal recessive agammaglobulinemia)
   ❑ Other non-SCID combined immunodeficiency disorder, ***specify:*** ____________________________________
   ❑ Common variable immunodeficiency (CVID)
   ❑ Hypogammaglobulinemia (unspecified) or other predominant antibody deficiency disorder
   ❑ Selective IgA deficiency
   ❑ Selective IgM deficiency
   ❑ IgG subclass deficiency
   ❑ Specific antibody deficiency
   ❑ Other immunodeficiency disorder/none of the above, ***specify*:** ____

9. ***ACTION REQUIRED:*** Please indicate and attach a copy of the following **pre-treatment** laboratory information (where applicable):
   - IgG (total) level: ___________ mg/dL
     a) Is IgG (total) level within the normal reference range? ❑ Yes ❑ No
     b) If No, is the IgG level greater than or equal to (≥) 2 SD below the mean for age? ❑ Yes ❑ No
   - IgG subclass levels:
     a) IgG1 ___________ mg/dL
     b) IgG2 ___________ mg/dL
     c) IgG3 ___________ mg/dL
     d) Other___________
     e) Are the IgG subclass levels within the normal reference range? ❑ Yes ❑ No
     f) If No, is the level(s) greater than or equal to (≥) 2 SD below the mean for age? ❑ Yes ❑ No
     g) Were IgG subclass levels measured on at least 2 different occasions? ❑ Yes ❑ No
   - IgA level: ___________ mg/dL
     a) Is the IgA level within the normal reference range? ❑ Yes ❑ No
   - IgM level: ___________ mg/dL
     a) Is the IgM level within the normal reference range? ❑ Yes ❑ No

10. *If diagnosis is severe combined immunodeficiency,* are maternal T cells present in the circulation?
    If Yes, no further questions. ❑ Yes ❑ No

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11. *If diagnosis is severe combined immunodeficiency,* what is the patient's CD3 T cell count? __________ per microliter ***ACTION REQUIRED: Attach a copy of the laboratory report with lymphocyte subset enumeration by flow cytometry.*** *No further questions*

12. Has the patient demonstrated an impaired antibody response to vaccination with a pneumococcal polysaccharide vaccine? ***ACTION REQUIRED: If yes, please attach a copy of the laboratory report with post-vaccination titers.***
❑ Yes ❑ No ❑ Not applicable

13. If applicable, was the diagnosis confirmed by molecular or genetic testing? ***ACTION REQUIRED: Please attach a copy of the laboratory report or other medical record that shows the results of molecular/genetic testing.***
❑ Yes ❑ No ❑ Not applicable to diagnosis

14. Have other causes of immune deficiency been excluded (eg, drugs, infectious disease, malignancy)?
❑ Yes ❑ No ❑ Not applicable to diagnosis

15 Does the patient have a history of recurrent bacterial infections (eg, pneumonia, otitis media, sinusitis, sepsis, gastrointestinal infections)? ❑ Yes ❑ No

16. Was the immune globulin therapy initiated in the hospital setting? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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