

Medicare Advantage Drugs/Biologics Part B Prior Authorization Form



Part B Step Therapy – Intravenous Immune Globulin – Alyglo[®], Asceniv[®], Bivigam[®], Panzyga[®], Oivigy, Yimmugo[®]

This form applies to all HealthSpring Medicare Advantage markets. It does not apply to Medicaid only and Medicare-Medicaid Plans (MMP). Please fax to **877-730-3858** | Phone: **888-454-0013**

To ensure your request is processed in a timely manner, please submit all pertinent clinical information.

<input type="checkbox"/> Expedited – defined as danger to a member’s health if not provided within 24 hours		
Member name		Member date of birth
Requesting provider		Member ID
Contact person		Date of service
Address		
NPI	Phone	Fax

If referring to a servicing provider, the information below must be submitted.	
Servicing provider	Phone
Contact person	Fax
Address	NPI
<input type="checkbox"/> Check here if servicing provider is out of network. Please explain.	
Who will supply the medication? <input type="checkbox"/> Provider office <input type="checkbox"/> Outpatient hospital/clinic <input type="checkbox"/> Pharmacy not located within the servicing facility	Please select place of service by checking only one of the boxes <input type="checkbox"/> Provider office <input type="checkbox"/> Outpatient hospital/clinic <input type="checkbox"/> Other. Please specify
Diagnosis codes	Diagnosis

Please attach all required documentation: recent clinical notes, copy of the prescription or provider order, and relevant diagnostic lab results.				
HPCS codes	Drug (if applicable)	Dose (if applicable)	Frequency	Duration
Is this a new start or a continuation of therapy within the past 365 days?				
Has the member had an intolerance or an inadequate response to two Step 1 alternatives (Flebogamma DIF [®] , Gammagard Liquid [®] , Gammagard S/D [®] , Gammaked [®] , Gammaplex [®] , Gamunex-C [®] , Octagam [®] , Privigen [®] , Gammagard Liquid ERC)?*				
If the member is unable to try two Step 1 alternatives (Flebogamma DIF [®] , Gammagard Liquid [®] , Gammagard S/D [®] , Gammaked [®] , Gammaplex [®] , Gamunex-C [®] , Octagam [®] , Privigen [®] , Gammagard Liquid ERC), please provide the reason(s) an exception should be made to the step therapy requirement.				

*HealthSpring requires prior authorization for Step 1 alternatives (Flebogamma DIF[®], Gammagard Liquid[®], Gammagard S/D[®], Gammaked[®], Gammaplex[®], Gamunex-C[®], Octagam[®], Privigen[®], Gammagard Liquid ERC).