ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

DOC TYPE 1M

Venoglobulin®, Gamimune®, Sandoglobulin®, Hizentra (SQ)®, Vivaglobin (SQ)® (Immune Globulins) Prior Authorization Form

****NOTICE: Medicare** – If approved, covered under Medicare Part B for Primary Immune Deficiency, otherwise covered under Medicare Part D.**

Complete Patient and Physician Information (PLEASE PRINT)

Step 1:	
Patient Name:	Physician Name:
Address:	Address:
Member ID:	NPI#:
Member DOB:	Phone #:
Service Provider Pharmacy Name:	Fax #:
	Person completing form:
Pharmacy Phone:	Date of Service:

Step 2:		
Complete the Clinical Assessment		
Diagnosis (please check one)	▪ Primary immunodeficiency disorders, including: ☐ Congenital agammaglobulinemia ☐ Common variable hypogammaglobulinemia ☐ X-linked immunodeficiency with Hyper IgM ☐ Combined immunodeficiency, e.g., Wiskott-Aldrich Syndrome ☐ Other:	ICD-9/10 =
	**** All FDA approved diagnoses are covered for Medicare members***	
Clinical Consideration	☐ For Vivaglobin or Hizentra, consider IV therapy before use of SQ therapy because of cost differential. **Any use for treatment of any other condition, including IgA deficiency, requires a medical review by a medical director.**	
HCPCS Code:		
Supporting Documentation	Please attach a copy of the clinical information or provide ALL of the information below: ☐ Venoglobulin® or ☐ Gamimune® or ☐ Sandoglobulin® or ☐ Hizentra® or ☐ Vivaglobin® Strength _____ Sig _____ Qty _____ Duration _____	
☐ Inpatient stay ☐ Observation stay ☐ Outpatient services ☐ Office ☐ Home		
Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**		

Step 3
Fax completed form to **Rocky Mountain Health Plans: 877-201-7302 or 970-254-5738**

The preauthorization for services noted in this form is only for the time period during which the patient remains eligible on the patient's current health benefit plan or for a shorter period as specified in this form. Rocky Mountain Health Plans is not financially responsible for the services that are preauthorized if the patient is not eligible at the date services are provided. Further as permitted by applicable law, this preauthorization is subject to concurrent review as to medical necessity, appropriateness of efficacy and coverage for services being provided and is subject to the terms and conditions in the member's health benefit contract, including but not limited to coordination of benefits, provisions, preexisting conditions and limitations, and any agreements between Rocky Mountain Health Plans and the health care provider. Billing for the services preauthorized on this form is subject to nationally standardized rules for coding and paying health services as used by Rocky Mountain Health Plans.

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