



**Venoglobulin®, Gamimune®, Sandoglobulin®, Vivaglobin (SQ)®  
(Immune Globulins)**

**Prior Authorization Form**

**Complete Patient and Physician Information (PLEASE PRINT)**

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

<b>Step 2:</b>		
<b>Complete the Clinical Assessment</b>		
Diagnosis (please check one)	<ul style="list-style-type: none"> <li>▪ Primary immunodeficiency disorders, including:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Congenital agammaglobulinemia</li> <li><input type="checkbox"/> Common variable hypogammaglobulinemia</li> <li><input type="checkbox"/> X-linked immunodeficiency with Hyper IgM</li> <li><input type="checkbox"/> Combined immunodeficiency, e.g., Wiskott-Aldrich Syndrome</li> <li><input type="checkbox"/> Other:</li> </ul> </li> </ul>	ICD-9 =
Clinical Consideration	<input type="checkbox"/> For Vivaglobin, consider IV therapy before use of SQ therapy because of cost differential. <p style="text-align: center;"><b>Any use for treatment of any other condition, including IgA deficiency, requires a medical review by a medical director.</b></p>	
<b>HCPCS Code:</b>		
Supporting Documentation	Please attach a copy of the clinical information or provide ALL of the information below: <input type="checkbox"/> Venoglobulin® or <input type="checkbox"/> Gamimune® or <input type="checkbox"/> Sandoglobulin® or <input type="checkbox"/> Vivaglobin® Strength _____ Sig _____ Qty _____ Duration _____	
<input type="checkbox"/> Inpatient stay <input type="checkbox"/> Observation stay <input type="checkbox"/> Outpatient services <input type="checkbox"/> Office <input type="checkbox"/> Home		
<p><b>Please attach all relevant medical records and test results.</b>  <b>Incomplete forms will not be processed.</b></p>		

<b>Step 3</b>
<p><b>Fax completed form to</b>  <b>Rocky Mountain Health Plans: 877-201-7302 or 970-254-5738</b>  <b>WINhealth Partners: 877-825-3018</b></p>

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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