

# IV and SC Immune Globulins (IVIg and SCIg)

## Prior Authorization Request (Physician to Complete)



Visit [www.wellmark.com](http://www.wellmark.com) for the Wellmark Drug List for current medication tier levels and updated PA Forms

### Facsimile Transmittal Sheet

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

To: Wellmark Pharmacy Services

From (Prescriber's Name): \_\_\_\_\_

Fax Number: (866) 884-4345

Prescriber's DEA Number: \_\_\_\_\_

Phone Number: (800) 600-8065

Prescriber's Phone Number: \_\_\_\_\_

Prescriber's Specialty: \_\_\_\_\_

Prescriber's Fax Number: \_\_\_\_\_

Prescriber's Office Address: \_\_\_\_\_  
Street Suite # City State Zip

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_ Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Does the patient have one of the following conditions/indications?

- Primary immune deficiency disorders, including combined immunodeficiencies  
Type: \_\_\_\_\_
- Severe autoimmune mucocutaneous blistering diseases, treatment refractory  
Type: \_\_\_\_\_
- Autoimmune and inflammatory disorders  
Type: \_\_\_\_\_
- Neuroimmunological disorders  
Type: \_\_\_\_\_
- Hematological disorders  
Type: \_\_\_\_\_
- Infectious diseases  
Type: \_\_\_\_\_
- Acute humoral rejection
- Pre- or post- solid organ transplant in patients at high risk of or for treatment of antibody-mediated rejection

2. Is the request for  IV or  SQ Immune Globulin?

3. Dose per injection: \_\_\_\_\_ mg Frequency of injection: \_\_\_\_\_ per \_\_\_\_\_

4. What is the HCPC billing code? \_\_\_\_\_

Printed Name

Signature

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