Please complete ALL information below and fax your request to 1-888-671-5285

Gammagard Liquid & Gamunex-C Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Chronic inflammatory demyelinating polyneuropathy (CIDP) *For Gamunex-C only*
❑ Idiopathic thrombocytopenia purpura (ITP) *For Gamunex-C only*
❑ Multifocal motor neuropathy *For Gammagard Liquid only*
❑ Primary immunodeficiency syndrome
❑ Other diagnosis: ____ ICD-10 Code(s): ________________________________

Clinical Information:

Is this request for continuation of prior therapy? ❑ **Yes** ❑ **No**

For chronic inflammatory demyelinating polyneuropathy (CIDP), also answer the following:

Have the patient's progressive symptoms been present for at least 2 months? ❑ **Yes** ❑ **No**

Select if the patient has symptomatic polyradiculoneuropathy as indicated by the following:

❑ Progressive or relapsing **motor** impairment of more than one limb
❑ Progressive or relapsing **sensory** impairment of more than one limb

Select if the patient's electrophysiological findings have the following criteria present:

❑ Partial conduction block of 1 or more motor nerve
❑ Reduced conduction velocity of 2 or more motor nerves
❑ Prolonged distal latency of 2 or more motor nerves
❑ Prolonged F-wave latencies of 2 or more motor nerves or the absence of F waves

Reauthorization:

Is there documentation the patient has had a positive clinical response to therapy as measured by an objective scale (e.g., Rankin, Modified Rankin, Medical Research Council [MRC] scale)? ❑ **Yes** ❑ **No**

Is there documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect? ❑ **Yes** ❑ **No**

For idiopathic thrombocytopenia purpura (ITP), also answer the following:

Does the patient have documented platelet count of less than 50 x 10^9/L? ❑ **Yes** ❑ **No**

For multifocal motor neuropathy, also answer the following:

Does the patient have weakness with slowly progressive or stepwise progressive course over at least one month? ❑ **Yes** ❑ **No**

Does the patient have asymmetric involvement of two or more nerves? ❑ **Yes** ❑ **No**

Select if the patient has the following:

❑ Bulbar signs
❑ Motor neuron signs

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Reauthorization:

Is there documentation the patient has had a positive clinical response to therapy as measured by an objective scale (e.g., Rankin, Modified Rankin, Medical Research Council [MRC] scale)? ❑ **Yes** ❑ **No**

Is there documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect for the patient? ❑ **Yes** ❑ **No**

For primary immunodeficiency syndrome, also answer the following:

Select if the patient has clinically significant functional deficiency of humoral immunity as evidenced by the following:

- ❑ Documented failure to produce antibodies to specific antigens
- ❑ History of significant recurrent infections

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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