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

Hizentra® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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)

❑ Other diagnosis: ____________________________ ICD-10 Code(s): ____________________________

Clinical Information:

Has the patient had progressive symptoms 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 meet the following criteria:

- ❑ 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

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

Reauthorization:

If this is a reauthorization request, answer the following questions:

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**

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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