US Family Health Plan
Prior Authorization Request Form for
Subcutaneous Immunoglobulins (SCIG)
(Gammagard Liquid, Gammaked, Xembify, Hizentra, Cuvitru, Hyqvia)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
	_____		_____
Sponsor ID #	_____	Phone #:	_____
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. The provider acknowledges that Cutaquig and Gamunex-C do not require a prior authorization. Also note that Cutaquig is available at the Tier 1 (generic) copay.	☐ Acknowledged Proceed to question **2**	
2. Is the patient greater than or equal to 2 years of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Patient has primary immunodeficiency disease (any) - **Proceed to question 5** ☐ Patient has a chronic inflammatory demyelinating polyneuropathy (any)- **Proceed to question 5** ☐ Patient has another diagnosis not listed above for which chronic immunoglobulin replacement therapy is a guideline-recommended therapeutic option - **Proceed to question 4**	

4. Please document the Name of Guideline and Guideline Recommendation Strength.

Name of Guideline: _____

Guideline Recommendation Strength: _____

Proceed to question **5**

5. Has the patient not tolerated, had an adverse reaction to, and/or has a contraindication to Gamunex-C that is not anticipated with the chosen product (to include intolerance to increased volumes associated with subcutaneous delivery)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient not tolerated, had an adverse reaction to, or has a contraindication to Cutaquig that is not anticipated with the chosen product (to include known or increased risk for IgA hypersensitivity, inability to accurately monitor blood sugars, and/or increased risk from a higher osmolality product)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is this the first time this subcutaneous product will be used?	☐ Yes Proceed to question **8**	☐ No Proceed to question **10**
8. Was the patient previously treated with an intravenous immunoglobulin?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. Has the provider followed package label directions to converting from intravenous dose (by mass) to the subcutaneous dose?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Does the patient agree to be monitored at indicated intervals to establish therapeutic immunoglobulin levels?	☐ Yes **Sign and dae below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge.
Please sign and date:

Prescriber Signature _____ Date _____