



Hepatitis B Immune Globulins
Hepagam B [IM] J1571,
Hepatitis B immune globulin [IV] J1573
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

<input type="checkbox"/>	NEW START - Start Date: _____	<input type="checkbox"/>	Continuation (within 365 days): Date of last treatment _____
<input type="checkbox"/>	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone _____ / Fax _____		

MEMBER INFORMATION

*Name: _____ *ID#: _____ *DOB: _____

PRESCRIBER INFORMATION

*Name: _____ MD FNP DO NP PA *Phone: _____

*Address: _____ *Fax: _____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name: _____ Phone: _____

*Address: _____ Fax: _____

PROCEDURE / PRODUCT INFORMATION

HCCP Code	Name of Drug <input type="checkbox"/> Self-administered	Dose (Wt: _____ kg Ht: _____)	Frequency	End Date if known

Chart notes attached. **Other important information:** _____

Diagnosis: ICD10: _____ **Description:** _____

Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

New Start or Initial Request: (Clinical documentation required for all requests)
 Provider has reviewed the attached “Criteria for Approval” and attests the member meets ALL required PA criteria.
 If not, please provide **clinical rationale** for formulary exception: _____

Continuation Requests: (Clinical documentation required for all requests)
 Provider has reviewed the attached “Criteria for Continuation” and attests the member meets ALL required PA Continuation criteria.
 Patient had an adequate response or significant improvement while on this medication.
 If not, please provide clinical rationale for continuing this medication: _____

ACKNOWLEDGEMENT

Request By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.**

Prior Authorization Group – Hepatitis B Immune Globulin PA

Drug Name(s):

**HEPAGAM [INTRA-MUSCULAR INJECTION]
HEPATITIS B IMMUNE GLOBULIN [INTRA-VENOUS INJECTION]**

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Patient does not have an IgA deficiency with antibodies against IgA.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
 - If the member meets all these criteria, they may be approved by the Plan for the requested drug.
 - Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approval will be for 12 months

FDA Indications:

IVIG Products:

1. Hepatitis B, Postexposure; Prophylaxis
2. Hepatitis B; Prophylaxis - Transplantation of liver

Off-Label Uses:

N/a

Other Clinical Consideration:

N/A

Resources:

https://www.micromedexolutions.com/micromedex2/librarian/CS/2E19F7/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/92434E/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=HepaGam%20B&UserSearchTerm=HepaGam%20B&SearchFilter=filterNone&navitem=searchGlobal