Antithymocyte/Lymphocyte Immune Globulins
Atgam (antithymocyte globulin equine) J7504, Thymoglobulin (antithymocyte globulin rabbit) J7511
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.*

☐	**NEW START - Start Date:**______________	☐	**Continuation** (within 365 days)**:** Date of last treatment _______________
☐	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

HCPC Code	**Name of Drug** ☐ 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.

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Lymphocyte Immune Globulins PA

Drug Name(s):

ATGAM	ANTITHYMOCYTE GLOBULIN-EQUINE
THYMOGLOBULIN	ANTITHYMOCYTE GLOBULIN-RABBIT

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. 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.
- Continuation Requests: Provider must verify continued clinical benefit in confirmatory trial(s).

Exclusion Criteria:
Acute or chronic infections that make any additional immunosuppression contraindicated

Prescriber Restrictions:
N/A

Coverage Duration:
Approval will be for 12 months

FDA Indications:

Atgam

- Aplastic anemia (Moderate to Severe), In patients unsuitable for bone marrow transplantation
- Renal transplant rejection, When used with conventional therapy at the time of rejection; Adjunct

Thymoglobulin

- Renal transplant rejection, In combination with other immunosuppressive agents
- Renal transplant rejection, In combination with other immunosuppressive agents; Prophylaxis

Off-Label Uses:

Atgam

- Bone marrow transplant
- Myelodysplastic syndrome

Thymoglobulin

- Acquired aplastic anemia
- Cardiac transplant rejection
- Cardiac transplant rejection; Prophylaxis (pediatric only)
- Familial hemophagocytic lymphohistiocytosis
- Graft versus host disease, In patients receiving unrelated donor hematopoietic stem cell transplantation for hematologic malignancies; Prophylaxis
- Liver transplant rejection
- Liver transplant rejection; Prophylaxis
- Lung transplant rejection; Prophylaxis
- Rejection of pancreas transplant
- Rejection of pancreas transplant; Prophylaxis
- Rejection of intestine transplant; Prophylaxis
- Rejection of pancreas transplant; Prophylaxis

CLINICAL / CMS ONLY

Age Restrictions:

Safety and efficacy not established in pediatric patients

Other Clinical Consideration:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/BDC0BD/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/7DF1F0/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Antithymocyte+Globulin+Equine&fromInterSaltBase=true&UserMdxSearchTerm=%24userMdxSearchTerm&false=null&=null#

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CLINICAL / CMS ONLY