



**Phone: 800-842-2015 Fax: 877-837-5922**

<b>PATIENT DATA</b>	Last Name	First Name	Policy Number	Date of Birth	Age
<b>REQUESTING PHYSICIAN DATA</b>	Last Name	First Name	Contact Name	Fax Number ( )	
BCBSLA Provider Number	Area of Practice/Specialty	Name of Place of Treatment	Treatment Ctr Provider #	Phone Number ( )	
<b>BILLING DATA</b>	Diagnosis Code(s) (ICD-9): 1) 2)		CPT-4/HCPCS Code	Other Codes	

**DRUG INFORMATION**

<input type="checkbox"/> Initial Request (New Start)		<input type="checkbox"/> Continuation Request	
<input type="checkbox"/> FLEBOGAMMA®	<input type="checkbox"/> OCTAGAM®	Dosage and Frequency	Anticipated Start Date
<input type="checkbox"/> GAMMAGARD S/D®	<input type="checkbox"/> PANGLOBULIN NF®		
<input type="checkbox"/> GAMUNEX®	<input type="checkbox"/> PRIVIGEN®		
<input type="checkbox"/> GAMUNEX-C®	<input type="checkbox"/> VIVAGLOBIN®		
<input type="checkbox"/> IVEEGAM EN®	<input type="checkbox"/> OTHER _____		
<input type="checkbox"/> HIZENTRA®			

**INDICATION / DIAGNOSIS**

<input type="checkbox"/> Primary humoral Immunodeficiency (including congenital agammaglobulinemia, hypogammaglobulinemia, common variable immunodeficiency, severe combined immunodeficiency, Wiskott-Aldrich syndrome and X-linked immunodeficiency) <input type="checkbox"/> Idiopathic Thrombocytopenia Purpura (ITP) <input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy (CDIP) <input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL) <input type="checkbox"/> Post Bone Marrow Transplant <input type="checkbox"/> Prevention of Infections <input type="checkbox"/> Treatment of Autoimmune Thrombocytopenic Purpura <input type="checkbox"/> Refractory Dermatomyositis (DM) <input type="checkbox"/> Kawasaki Syndrome <input type="checkbox"/> Guillain-Barre Syndrome	<input type="checkbox"/> Multifocal motor neuropathy in patients with anti-GM1 antibodies and conduction block <input type="checkbox"/> Fetal alloimmune thrombocytopenia <input type="checkbox"/> Myasthenic crisis (i.e., an acute episode of respiratory muscle weakness) in patients with contraindications to plasma exchange <input type="checkbox"/> Myasthenia gravis in patients with chronic debilitating disease in spite of treatment with cholinesterase inhibitors, or complications from or failure of steroids and/or Azathioprine <input type="checkbox"/> Prior to solid organ transplant, treatment of patients at high risk of antibody-mediated rejection, including highly sensitized patients, and those receiving an ABO incompatible organ <input type="checkbox"/> Following solid-organ transplant, treatment of antibody-mediated rejection <input type="checkbox"/> Other Indication _____
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**CLINICAL INFORMATION (Check ALL that apply)**

<input type="checkbox"/> Yes <input type="checkbox"/> No Last two office progress notes attached <input type="checkbox"/> Yes <input type="checkbox"/> No Neurological exam results attached <input type="checkbox"/> Yes <input type="checkbox"/> No EMG/nerve conduction results attached <input type="checkbox"/> Yes <input type="checkbox"/> No Nerve biopsy results attached <input type="checkbox"/> Yes <input type="checkbox"/> No Lumbar puncture results attached <input type="checkbox"/> Yes <input type="checkbox"/> No VDRL results attached <input type="checkbox"/> Yes <input type="checkbox"/> No Documentation of failed therapies attached	<input type="checkbox"/> Yes <input type="checkbox"/> No Bone marrow report attached <input type="checkbox"/> Yes <input type="checkbox"/> No IgG levels attached <input type="checkbox"/> Yes <input type="checkbox"/> No CBC results attached <input type="checkbox"/> Yes <input type="checkbox"/> No Will the patient be receiving the drug in the physician's office? If no, <b>list name</b> of servicing provider _____ List any other relevant clinical info if applicable: _____ _____ _____
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<b>PHYSICIAN SIGNATURE</b> _____ <b>Prescribing Physician</b>	<b>DATE</b> _____
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**Note:** On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

**Incomplete forms will not be processed**