Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229

Aetna Better Health of KS
PA Pharmacy Phone 855-221-5656
PA Pharmacy Fax 844-807-8453
PA Medical Phone 855-221-5656
PA Medical Fax 855-225-4102

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929
PA Medical Phone 877-644-4623
PA Medical Fax 888-453-4756

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328
PA Medical Phone 866-604-3267
PA Medical Fax 866-946-6474

Prior Authorization for Intravenous Immune Globulins (IVIG)

Immune globulin (human) intravenous (Bivigam®)
Immune globulin (human) intravenous (Carimune NF®)
Immune globulin (human) intravenous (Flebogamma DIF®)
Immune globulin (human) intravenous (Gammagard S/D®)
Immune globulin (human) intravenous (Gammaplex®)
Immune globulin (human) intravenous (Octagam®)
Immune globulin (human) intravenous (Privigen®)
Immune globulin (human) intravenous/subcutaneous (Gammagard®)
Immune globulin (human) intravenous/subcutaneous (Gammaked®)
Immune globulin (human) intravenous/subcutaneous (Gamunex-C®)
Immune globulin (human) subcutaneous (Hizentra®)

Beneficiary Information

Name: ______________________________

Medicaid ID #: ____________________ Date of Birth: ____________________

Billing Provider Information (Pharmacy, Physician or Facility)

Name: ____________________ Medicaid ID #: ____________________

NPI #: ______________ Phone #: ______________ Fax #: ______________

Requested Drug: ____________________ NDC: ____________________

Procedure Code Requested: ____________ Total # procedure code units requested/time frame: ____________

Prescriber Information

Name: ____________________ Medicaid ID #: ____________________

NPI #: ______________ Phone #: ______________ Fax #: ______________

Clinical Prior Authorization for Chronic Use

Please select the appropriate diagnosis for this request:

☐ Autoimmune mucocutaneous blistering diseases
☐ Bone Marrow Transplant
☐ Dermatomyositis
☐ Human Immunodeficiency Virus (HIV)
☐ Lambert Eaton
☐ Multiple Sclerosis
☐ Primary Immune Deficiency
☐ B-cell Chronic Lymphocytic Leukemia
☐ Chronic Demyelinating Polyneuropathy
☐ Hemolytic Anemia
☐ Idiopathic thrombocytopenic purpura (ITP)
☐ Multifocal Motor Neuropathy
☐ Polymyositis
☐ Solid Organ Transplant

Clinical Prior Authorization for Acute Treatment

Please select the appropriate diagnosis for this request:

- ☐ Autoimmune Uveitis
- ☐ Encephalitis (anti-NMDA or meningoencephalitis)
- ☐ Fetal or Neonatal Alloimmune Thrombocytopenia
- ☐ Graves Ophthalmopathy
- ☐ Guillain Barre Syndrome
- ☐ Kawasaki Disease
- ☐ Myasthenia Gravis
- ☐ Neonates (infection/sepsis prevention)
- ☐ Neuropathy (paraprotein associated)
- ☐ Parvovirus B19
- ☐ Rotavirus Enterocolitis
- ☐ Sepsis treatment
- ☐ Stevens Johnson
- ☐ Stiff Man Syndrome
- ☐ Toxic Shock

Prescriber's Signature: ____ Date: __________________________

This form will be returned unprocessed if it is not completed in its entirety.