

**Physician's Prior Authorization Questionnaire
Hizentra®**

Patient:

ID#:

DOB:

Patient Address:

Hizentra® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____

2. Does the patient have one of the following primary immunodeficiencies?

- a. Congenital agammaglobulinemia (X-linked agammaglobulinemia): Yes No
- b. Common variable immunodeficiency (panhypogammaglobulinemia): Yes No
- c. X-linked immunodeficiency hyperimmunoglobulin M: Yes No
- d. Severe combined immunodeficiency: Yes No
- e. Wiskott-Aldrich syndrome: Yes No

3. Does the patient have a diagnosis of hypogammaglobulinemia? Yes No

If yes,

- a. Does the patient have frequent bacterial infections: Yes No
- b. Is the patient unable to form antibodies against polysaccharide and protein antigens?
 Yes No

4. Has the patient undergone previous treatment with intravenous immunoglobulin (IVIG)? Yes No

Hizentra® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx