



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.*

<input type="checkbox"/>	Standard Request– (72 Hours)	<input type="checkbox"/>	Urgent Request (standard time frame could place the member's life, health or ability in serious jeopardy)
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	Dose (Wt: _____ kg Ht: _____)	Frequency	End Date if known

Self-administered Provider-administered Home Infusion

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)
 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 – Antithymocyte/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



Part B Prior Authorization Step Therapy Guidelines

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