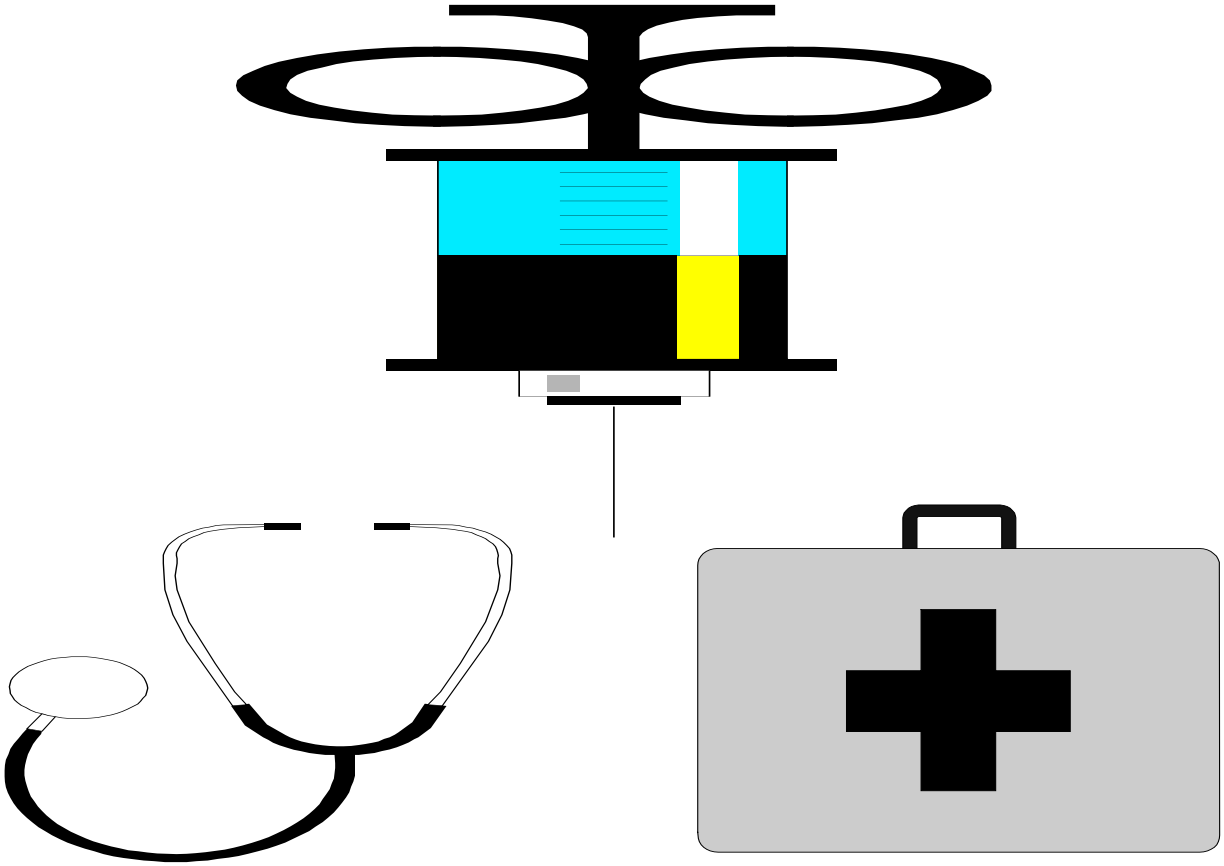
MONTANA MEDICAID

Home Infusion Therapy
Provider Manual



Department of Public Health and Human Services
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A. Introduction

Home infusion therapy is a comprehensive treatment program of pharmaceutical products and clinical support services provided to individuals at sites alternate to the inpatient setting. Sites may include: patient's home, office care room, nursing facility, etc. A physician's authorization for home infusion therapy allows Medicaid recipients to leave the hospital care setting and continue medical care at home. This significantly reduces Medicaid hospitalization costs. Under the guidance of the recipient's physician, the licensed home infusion therapy provider develops and implements a treatment program to meet the particular requirements of the recipient.

Home infusion therapy agencies must be licensed under Montana's health care service licensing laws. Due to the nature of home infusion therapy, the Department of Public Health and Human Services determined that regulatory oversight was necessary to fulfill the state's obligation ensuring consumer safety. To obtain licensing requirements and procedures, write or call: **Department of Public Health and Human Services, Health Care Facility Licensure Bureau, Quality Assurance Division, PO Box 202951, Helena, MT 59620 (Phone 406-444-2868).**

B. Definitions

Antineoplastic
Any agent that prevents the development, growth or proliferation of malignant cells.

Bolus
A small volume of drug which is administered directly into the vein, usually over a short time period of 3-5 minutes.

Continuous
A controlled method of prolonged drug administration that includes the ability to control the delivery rate. This system permits the drug to be available to the body at a constant level.

Cytotoxic Agents
Chemicals that destroy cells or prevent their multiplication. This group of compounds is most often used in cancer chemotherapy.

Duodenostomy Tube
A tube inserted into a surgically formed permanent opening into the duodenum through the wall of the abdomen.

Electronic Infusion Device (EID)
A device for administering parenteral infusions. The device may be used to signal the completion of the IV. It may also have an alarm that sounds when a preset pressure limit is sensed indicating an occlusion restricting the line flow.

Enteral Tube Feeding
Feeding an appropriate formula to a patient by means of a tube passed into the stomach or small intestine from the nasal passage. Used for patients who are unwilling or unable to masticate or swallow food.

Gastrostomy Tube
A tube introduced into the stomach by the surgical creation of a gastric fistula through the abdominal wall. This is necessary in some cases of cicatricial stricture of the esophagus in order to introduce food into the stomach.

Infusion
A parenteral solution administered intravenously or subcutaneously over an extended period of time. Always requires a rate controlling device, which may be an EID.

Intravenous (IV)
Injection of a solution directly into the vein, usually the cephalic or median basilica vein of the arm.

Intravenous feeding
Providing nutritional requirements intravenously by carefully controlling the composition of fluid given with respect to total calories derived from protein hydrolysate and dextrose, “fats and fiber,” and electrolytes, minerals and vitamins.

Infusion Pump
Electronic or mechanical device designed to provide continuous, intermittent, circadian, cyclical and/or bolus delivery of medications or nutrients via parenteral or enteral routes. The infusion rate is controlled and with electronic infusion devices, the rate is adjustable. Pumps can control infusion rates by the bore of the tubing and volume of the pump; a sensor which applies pressure on the tubing carrying the infused solution; or by placing constant pressure on a syringe at a programmed rate. Infusion pumps are generally considered to be closed systems, which helps to prevent inadvertent contact with sterile solutions.

Jejunostomy Tube
A tube inserted into a surgically created passage between two parts of the jejunum.

Parenteral
Denoting any medication route other than the alimentary canal, such as intravenous, subcutaneous, intramuscular, or mucosal.

Subcutaneous
Infusion of solutions into the subcutaneous tissue beneath the skin.

C. Covered Services

The Montana Medicaid Home Infusion Therapy Program covers the preparation and administration of parenteral medications and parenteral or enteral nutritional services provided in the patient's residence. Home infusion therapy services include all pharmacist professional services, all home infusion therapy agency staff services, and all associated medical equipment and supplies.

The professional physician and nursing services and most covered drugs associated with the provision of home infusion therapy are reimbursed separately.

1. TPN - Total Parenteral Nutrition - PRIOR AUTHORIZATION REQUIRED

Parenteral administration of any IV solution including amino acids and one or more non-protein sources of calories plus electrolytes, minerals, vitamins, insulin, or other medications for a patient who is unable to take or absorb food orally. Always requires an infusion pump. **The basic parenteral nutrition solution containing the carbohydrates and amino acids is included in the per diem.** Additives to the solution that are covered drugs are separately billable.

2. Enteral Therapy

Administration of enteral nutrition per nasogastric, gastrostomy or jejunostomy tubes for adults, or orally for children under 21, when the patient is medically unable to maintain adequate nutrition. **Nutritional formula is included in the per diem rate.**

3. IV Antibiotics - PRIOR AUTHORIZATION REQUIRED

Intravenous administration of antibacterial, antiviral or antifungal medications appropriately constituted and admixed with an IV solution. Treatment normally requires an infusion pump, especially if more than one antibiotic is being infused or if prescribed for a pediatric patient. Covered drugs are separately billable.

4. Pain Management

Intravenous or subcutaneous administration of narcotic analgesics possibly admixed in IV solutions with individualized dosage units and delivery systems per patient specific needs. Always requires an infusion pump. The fee applies regardless of the method of delivery or the number of cassettes used per week. Covered drugs are separately billable.

5. Chemotherapy

Parenteral administration of antineoplastic medications appropriately constituted and possibly admixed with an IV solution and requiring cytotoxic precautions in preparation, administration, and disposal of supplies. Often requires an infusion pump or specialized delivery system. The fee applies regardless of the method

of delivery. Covered drugs are separately billable.

6. Hydration

Parenteral administration of combinations of dextrose or its derivative and/or saline solution, or Lactated Ringer's Solution and possibly electrolytes to correct or prevent dehydration. Treatment may require an infusion pump.

7. Preterm Labor Prevention

Subcutaneous or oral administration of terbutaline sulfate for prevention and control of preterm uterine contractions. Covered drugs are separately billable.

- Level I - AUM MONITOR ONLY **OR** TERBUTALINE THERAPY VIA PUMP ONLY - Provides an increased level of surveillance for patients at high risk of experiencing preterm labor who can benefit from more frequent clinical contact and daily collection and assessment of uterine and other biophysical data.

- Level II - AUM MONITOR WITH ORAL MEDICATION - Provides an increased level of surveillance for patients at high risk of experiencing preterm labor who can benefit from more frequent clinical contact and daily collection and assessment of uterine and other biophysical data.

- Level III - AUM MONITOR WITH SUBCUTANEOUS TERBUTALINE THERAPY - For patients who have experienced preterm labor in their current pregnancy and whose uterine activity can no longer be controlled by oral tocolytic therapy. Also for patients who because of their obstetrical history or clinical status are unable to risk an episode of preterm labor.

8. Gamma Globulin / Immunoglobulin - PRIOR AUTHORIZATION REQUIRED

Intravenous administration of immunoglobulin (IVIG). IVIG are a group of serum proteins synthesized by B lymphocytes and plasma cells that play a major role in the humoral immune system. Covered drugs are separately billable.

9. Antiemetic

Therapy that prevents or alleviates nausea and vomiting. Covered drugs are separately billable.

10. Steroidal Therapy

Anti-inflammatory treatment with various steroid hormones used to control acute or chronic symptoms such as those of multiple sclerosis. Covered drugs are separately billable.

11. Cardiovascular / IV Cardiac Therapy

Intravenous administration of medications to improve cardiac performance. Therapy requires central venous access and the use of an infusion pump due to the potential for adverse cardiac effects. Covered drugs are separately billable.

12. IV Dobutamine Therapy - PRIOR AUTHORIZATION REQUIRED

Intravenous administration of dobutamine for patients with a diagnosis of chronic refractory CHF. Covered

drugs are separately billable.

13. Desferal Therapy - PRIOR AUTHORIZATION REQUIRED

Therapy that is used parenterally to reduce the iron stored in the body in patients with hemochromatosis, acute iron poisoning, or abnormal storage of iron due to multiple blood transfusions. Covered drugs are separately billable.

14. Heparin Therapy

Therapy that inhibits coagulation by preventing conversion of prothrombin to thrombin by forming an antithrombin, and by preventing liberation of thromboplastin from blood platelets. Low molecular weight heparin is not billable as an infusion therapy. Covered drugs are separately billable.

15. Other Infusion Therapies - PRIOR AUTHORIZATION REQUIRED

Anticipating that new infusion therapies will be developed or that a current therapy has been overlooked, the Department will consider authorization of other therapies on an individual basis. These special requests may require peer review and will require cost information for setting a per diem rate.

D. Non-covered Services

Medications which can be appropriately administered orally, through intramuscular or subcutaneous injection, or through inhalation, and drug products that are not FDA approved or whose use in the non-hospital setting present an unreasonable health risk to the patient are **NOT** covered as home infusion therapy services. The Department determines which specific therapies are not allowed as home infusion therapy services in consultation with the Department's Drug Use Review Board.

E. Reimbursement

Reimbursement for home infusion therapies under the Montana Medicaid Program will be the lessor of:

The provider's actual charge for the service;
The Department's fee schedule*.

*The fee schedule for home infusion therapy is a per diem fee that includes:

1. Equipment and Supplies

All equipment to include both rental and backup and supplies (excluding legend drugs) necessary to prepare and administer a medication either on site or in the patient's home.

2. Home Infusion Therapy Agency Staff Services

a. Preparation and revision of the plan of care;
b. Coordination of treatment with other health care providers;
c. Recipient and/or care giver training;
d. Clinical monitoring of laboratory values and therapy progression and reporting of clinical information to the recipient's physician and other health care providers;
e. Delivery, pick up and disposal of equipment, supplies and/or drugs;
f. 24-hour on call status; and
g. Any other services provided by the agency staff related to the recipient's home infusion therapy services.

3. Pharmacist professional services

a. Preparation and revision of the plan of care;
b. Preparation and compounding of drugs;
c. Monitoring of laboratory values and therapy progression and reporting clinical information to the recipient's physician and other health care providers;
d. 24-hour on-call status;
f. Delivery, pick up and disposal of equipment, supplies and/or drugs;
e. Any other services of the pharmacist related to the recipient's home infusion therapy services. Pharmacists professional fees do not include costs, fees or charges for the drugs that are compounded or administered.

F. Billing Instructions

Home Infusion Therapy requires coordinated services from (1) a licensed home infusion therapy provider; (2) a pharmacy provider for drugs; (3) registered nurses; and (4) physicians. The billing procedures for physicians are unchanged. Billing procedures for the other three components are described below.

BEGINNING WITH THE DECEMBER 1, 1996, DATE OF SERVICE, ONLY LICENSED HOME INFUSION THERAPY AGENCIES MAY BILL MONTANA MEDICAID FOR HOME INFUSION THERAPY SERVICES.

1. Home Infusion Therapy

a. **Provider Numbers** - Home infusion therapy providers must enroll with Montana Medicaid. Providers will be assigned Durable Medical Equipment (DME) numbers to bill infusion therapy per diem fees. A specialty code for infusion therapy has been added to the provider file to deny payment of infusion therapy procedure codes to providers not enrolled as infusion therapy providers.

b. **Usual and Customary Charge** - The per diem fees represent the maximum Medicaid will pay for a specific therapy. Providers are required to bill using their usual and customary charge which may be lower than the Medicaid maximum reimbursement.

c. **Billing Days** - The number of units billed is the number of days on which therapy is actually provided. For example, if a patient receives IV Antibiotics Q48 (every 48 hours) for two weeks, then the provider can only bill for 7 days of therapy. Note that the number of units billed must not exceed the number of days in the billing span.

d. **Co-Payment** - Co-payment for home infusion therapy is applied to the infusion procedure codes billed through the DME program. Co-payment for these services is $0.50 per line item.

e. **Third Party Liability (TPL)** - Providers are required to bill all third party payers (TPL) such as Blue Cross and Blue Shield as is customary in accordance with section VII of the Montana Medicaid Provider Handbook.

f. **Multiple Concurrent Therapy Discounts** - Providers will extend a 20% discount off the per diem rate when multiple concurrent therapies are used. The discount applies to the lower cost therapy. Providers will use the **discounted procedure code** when billing for multiple concurrent therapies.

g. **Billing form** - Providers use the HCFA 1500 form to bill infusion therapy per diem fees.

- **All PROCEDURE CODES use TYPE OF SERVICE "3". This is INDICATED IN Block 24 C, ON HCFA 1500 CLAIM FORM.**

- **Third party liability (TPL) and TPL payment MUST be reflected in blocks 11 and 29 of the HCFA 1500 claim form.**

h. **Procedure Codes** - The procedure codes for the infusion therapy per diem fees are listed below. DME procedure codes for items included in these per diem **MAY NOT** be billed concurrently with the per diem procedure codes.

Procedure Code	Therapy Description	Per Diem Rate	PA Required
Z9400	Total Parenteral Nutrition[1]	$225	Y
Z9401	Total Parenteral Nutrition[1] **Multiple Concurrent Therapy**	$180	Y
Z9405	Enteral Bolus[2]	$ 35	N
Z9406	Enteral Bolus[2] **Multiple Concurrent Therapy**	$ 28	N
Z9407	Enteral Pump[2]	$ 35	N
Z9408	Enteral Pump[2] **Multiple Concurrent Therapy**	$ 28	N
Z9410	IV Antibiotics - Q4, Q6, Q8	$150	Y
Z9411	IV Antibiotics - Q4, Q6, Q8 **Multiple Concurrent Therapy**	$120	Y
Z9412	IV Antibiotics - Q12, Q24, Q48, Q72	$125	Y
Z9413	IV Antibiotics - Q12, Q24, Q48, Q72 **Multiple Concurrent Therapy**	$100	Y
Z9420	Pain Management	$105	N
Z9421	Pain Management **Multiple Concurrent Therapy**	$ 84	N
Z9425	Chemotherapy - Q3 through Q24	$145	N
Z9426	Chemotherapy - Q3 through Q24 **Multiple Concurrent Therapy**	$116	N
Z9430	Hydration	$ 25	N

Procedure Code	Therapy Description	Per Diem Rate	PA Required
Z9431	Hydration **Multiple Concurrent Therapy**	$ 20	N
Z9435	Level I - AUM Monitor Only **or** Subcutaneous Terbutaline Only	$ 70	N
Z9436	Level I **Multiple Concurrent Therapy**	$ 56	N
Z9437	Level II - AUM Monitor and oral medication	$ 80	N
Z9438	Level II **Multiple Concurrent Therapy**	$ 64	N
Z9439	Level III - AUM Monitor with subcutaneous terbutaline therapy	$120	N
Z9440	Level III **Multiple Concurrent Therapy**	$ 96	N
Z9445	Gamma Globulin/Immunoglobulin	$ 25	Y
Z9446	Gamma Globulin/Immunoglobulin **Multiple Concurrent Therapy**	$ 20	Y
Z9450	Antiemetic Therapy - Q4, Q6, Q8	$150	N
Z9451	Antiemetic - Q4, Q6, Q8 **Multiple Concurrent Therapy**	$120	N
Z9455	Antiemetic Therapy - Q12, Q24, Q48, Q72	$125	N
Z9456	Antiemetic -Q12, Q24, Q48, Q72 **Multiple Concurrent Therapy**	$100	N
Z9465	Steroidal Therapy	$150	N
Z9466	Steroidal Therapy **Multiple Concurrent Therapy**	$120	N
Z9480	Cardiovascular/IV Cardiac Therapy	$105	N
Z9481	Cardiovascular/IV Cardiac Therapy **Multiple Concurrent Therapy**	$ 84	N
Z9482	Dobutamine Therapy	$105	Y

Procedure Code	Therapy Description	Per Diem Rate	PA Required
Z9483	Dobutamine Therapy **Multiple Concurrent Therapy**	$84	Y
Z9485	Desferal Therapy Q4, Q6, Q8	$150	Y
Z9486	Desferal Therapy Q4, Q6, Q8 **Multiple Concurrent Therapy**	$120	Y
Z9490	Desferal Therapy Q12, Q24, Q48, Q72	$125	Y
Z9491	Desferal Therapy Q12, Q24, Q48, Q72 **Multiple Concurrent Therapy**	$100	Y
Z9498	Heparin Therapy	$105	N
Z9499	Heparin Therapy **Multiple Concurrent Therapy**	$ 84	N

[1]Basic parenteral solution containing carbohydrates and amino acids is included in the per diem.
[2]Nutritional formula included in the per diem.

2. Legend Drugs

a. All pharmaceuticals associated with the delivery of an infusion therapy will be billed through the Medicaid pharmacy program using the **individual NDC of the product.** Reimbursement will be the lesser of the provider's usual and customary charge, direct price or AWP-10% plus a dispensing fee, or the Federal Upper Limit (FUL) plus a dispensing fee.

b. Co-payment - Separately billed drugs used **ONLY** in infused preparations will be exempt from co-pay when billing for these items through the pharmacy program. This will insure that co-payment is applied consistently to the service as opposed to each component. Any covered drug dispensed that **is not** a part of an infused mixture will be subject to the current co-payment applicable to the outpatient drug program.

Providers submitting claims through the point of sale system will override co-payment for drugs included in an infusion mixture by using certification "4" similar to the way co-payment is overridden for pregnant women. Providers submitting paper claims will override co-payment for drugs included in an infusion mixture by placing a "4" in the drug name field of the claim. Providers submitting claims by diskette will override co-payment for drugs included in an infusion mixture by entering a "Y" in the co-pay override field.

3. Nursing Services

a. **Home Health Agency** - Nursing services provided by an enrolled Medicaid home health

agency must be billed by that agency and not by the home infusion therapy provider. Nursing services are billed in accordance with current home health program procedures.

b. **Home Infusion Therapy Agency** - If nursing services are provided by registered nurses employed by the home infusion therapy agency, nursing services are billed as follows:

- **Providers must enroll as private duty nursing providers and use the private duty nursing agency provider number in billing for the nursing services.**

- **Use Procedure code Z0752 - RN Services provided for home infusion therapy - $10.00 per 30 minutes of patient care.**

Providers are responsible for maintaining documentation to support all nursing services billed. The Quality Assurance Division may be used to periodically verify billed nursing services.

Professional nursing services are NOT separately billable when home infusion therapy is provided in a nursing facility.

Nursing services provided to Medicaid HMO participants must bill the HMO. Claims for nursing services submitted to Medicaid for these patients will be denied.

G. Impact of Managed Care and Welfare Reform

The Department of Public Health and Human Services has two managed care programs -- PASSPORT to Health and HMO -- and a welfare reform initiative called "Families Achieving Independence in Montana" (FAIM). Recipients in PASSPORT or HMO must get approval before receiving HMO or PASSPORT-managed services, or those services will not be reimbursed. Able-bodied adults in FAIM are only eligible for Basic Medicaid, a smaller package of services than that available to most Medicaid recipients. The chart below shows whether home infusion therapy is a covered service and whether approval from the managed service provider is required. For more detail on PASSPORT, see Section XI of the Medicaid provider handbook; for more detail on HMOs see Section XII of the Medicaid provider handbook; for more details on FAIM see Section XIII of the Medicaid provider handbook.

If Medicaid card says recipient is on....	PASSPORT Managed Service	HMO Managed Service	FAIM (Basic Medicaid)
Home Infusion Therapy	Covered - do not need PASSPORT provider's approval for Medicaid to reimburse	Covered - do not need HMO provider's approval for HMO or Medicaid to reimburse	This service is **NOT COVERED** by Medicaid
Legend Drugs	Covered - do not need PASSPORT provider's approval for Medicaid to reimburse	Covered - do not need HMO provider's approval for HMO or Medicaid to reimburse	This service is covered by Medicaid
Nursing Services	Covered - do not need PASSPORT provider's approval for Medicaid to reimburse	Covered - **do** need HMO provider's approval for HMO or Medicaid to reimburse	This service is covered by Medicaid

H. Prior Authorization

1. Background

The Department requires prior authorization for some home infusion therapies. These requirements have been established after consultation with the Department's Drug Use Review Board. Criteria listed for each therapy are derived from reviews completed by the University of Montana's School of Pharmacy. The Montana-Wyoming Foundation for Medical Care administers the Home Infusion Therapy Prior Authorization Program for Montana Medicaid.

2. Authorization Required for Payment

Payment for home infusion therapies requiring prior authorization will be made only after approval is obtained from the Prior Authorization Unit and when the therapy prescribed for treatment satisfies one or more of the conditions set forth for each therapy. The prescriber (physician, etc.), pharmacist, or home infusion therapy provider should use the Request for Prior Authorization form for this purpose.

3. Prior Authorization Request Procedures

a. Prior authorization may be requested via telephone, FAX, or by mail to the Prior Authorization Unit and requires the information designated on the request form. Requests will be reviewed and approvals or denials will be made, in most cases, immediately. Unusual or special circumstance requests may require further peer review with a decision and response within 24 hours.

Requests received after regular working hours of 8 AM to 5 PM Monday through Friday or on weekends or holidays will be considered to be received at the start of the next working day. If the weekend/holiday request is for an emergency situation, therapies with an established per diem fee may be provided and payment will be authorized up to a maximum of three (3) days. Medicaid may routinely audit these emergency authorizations for validity and appropriateness. **Under no circumstances will therapies falling in the "other infusion therapies" category be authorized on an emergency basis.**

To request authorization by phone or fax, call:

(406) 443-6002 or (800) 395-7961 (phone)
(406) 443-4585 or (800) 497-8235 (fax)

b. Request for Prior Authorization Form
The information on the form will be required when phoning for prior authorization. Providers may make copies of the attached form for their use when faxing authorization requests or request additional copies from the Prior Authorization Unit.

c. The Prior Authorization Unit will complete the bottom section of this form and either approve or deny the request based on the criteria submitted. The Prior Authorization Unit will have access to on-line claims history to verify submitted criteria if necessary. If a prior

authorization request is denied, a copy of this form with the reason for denial will be sent to the provider submitting the request. Approvals of prior authorization requests will **not** be sent to providers unless requested.

I. Therapies Requiring Prior Authorization

1. Total Parenteral Nutrition - TPN

Payment for TPN may be authorized upon telephoned, FAXed, or written request by the physician, home infusion therapy provider or pharmacist to the PA unit only for those cases which meet the criteria listed below.

Recertification is required at 3 months, 9 months, and 24 months after the initiation of therapy. After two years, authorization will be determined on a case-by-case basis. If, at any time, there is a break in service to the patient of two consecutive months, the entire review process will begin again.

Patients must meet the following criteria:

a. A patient must be unable to meet nutrient requirements via the GI tract safely and adequately. Adequate nutrition cannot be completely possible by dietary adjustment, oral supplements, or tube enteral nutrition.

(1) The patient's GI tract must be severely diseased, preventing absorption of adequate nutrients to maintain weight and strength consistent with the patient's overall status. TPN must be necessary to sustain the patient's life.

(2) Examples of conditions and/or functional impairments that may qualify for coverage include, but are not limited to:

- Massive small bowel resection;
- Crohns' disease;
- Sprue;
- Short bowel syndrome;
- Radiation enteritis;
- Malabsorption documented by a physician;
- GI tract mechanical obstruction;
- A total caloric intake of 20-35 kcal/kg (of ideal body weight)/day constitutes nutritional dependence.

b. Peripheral parenteral nutrition may be used in selected patients to provide partial or total nutrition support for up to two weeks in patients who cannot ingest or absorb adequate oral or enteral tube-delivered nutrients, or when central-vein parenteral nutrition is not feasible.

(1) The patient should not have pulmonary edema, congestive heart failure (New York Heart Association Functional Class 3 or 4), or any other medical condition that

would increase the risk of home administration.

(2) Central-vein parenteral nutrition support, including support via a PICC line, is provided when parenteral feeding is indicated for longer than two weeks, peripheral venous access is limited, or nutrient needs are large or fluid restriction is required.

2. IV Antibiotic Therapy

Prior authorization is required for IV Antibiotic Therapy. Except as described below, IV Antibiotic Therapy of two weeks or less duration will be authorized upon request. For IV Antibiotic Therapy provided for more than two weeks, payment will be considered on an individual basis and may be authorized upon telephoned, FAXed, or written request by the physician, home infusion therapy provider, or pharmacist to the PA unit.

IV Antibiotic Therapy using IV ciprofloxin or metronidazole has not been found to have any therapeutic advantage over oral therapies. For that reason, prior authorization is always required for therapies using these drugs. Payment will be considered on an individual basis and may be authorized upon telephoned, FAXed, or written request by the physician, home infusion therapy provider, or pharmacist to the PA unit.

3. Gamma Globulin/Immunoglobulin Therapy (IVIG)

Prior authorization is required for the use of any IVIG product. Payment for these products will be authorized upon telephoned, FAXed, or written request by the physician, home infusion therapy provider, or pharmacist to the PA unit only for those cases in which there is a diagnosis of one of the following:

a. Primary immunodeficiency disorders with a history of recurrent infections
b. Idiopathic thrombocytopenic purpura:
   (1) children with newly diagnosed ITP who are not a risk for serious hemorrhage
   (2) chronic ITP
   (3) adult-onset ITP in those patients who do not respond to initial corticosteroid therapy
c. Allogeneic bone marrow transplantation
d. Symptomatic pediatric HIV infection and CD4 lymphocyte count greater than 200
e. Chronic lymphocytic leukemia patients with a history of at least one serious bacterial infection
f. Kawasaki syndrome
g. Guillain-Barre syndrome

4. IV Dobutamine Therapy

Prior authorization is required for IV dobutamine therapy. Payment for this therapy will be authorized upon telephoned, FAXed, or written request by the physician, home infusion therapy provider, or pharmacist to the PA unit only for those cases in which there is a diagnosis of chronic refractory CHF which meets the following criteria:

a. The patient shows no clinical improvement (FC-III or FC-IV) despite treatment with maximum or near-maximum tolerated doses of standard oral therapy for CHF (unless allergic or intolerant);
b. The patient is clinically stable on the dosage to be administered at home prior to discharge

from the hospital;

c. The patient demonstrates either an improvement in FC from IV to III, **or** an improvement in symptoms (less dyspnea, improved diuresis, improved renal function, and/or reduction in weight) and hemodynamic parameters (at least 20 percent increase in cardiac output, decreased pulmonary artery pressure, and/or a decrease in pulmonary capillary wedge pressure, measured invasively within six months prior to the initiation of therapy);

d. The patience demonstrates a clinical dependence on the inotrope as evidenced by deterioration in clinical status when the drug is tapered or discontinued.

5. Desferal Therapy

Prior authorization is required for IV desferal therapy. Payment for this therapy will be considered on an individual basis and may be authorized upon telephoned, FAXed, or written request by the physician, home infusion therapy provider, or pharmacist to the PA unit.

6. Other Therapies

Anticipating that new infusion therapies will be developed or that a current therapy has been overlooked, the Department will consider authorization of other therapies on an individual basis. These special requests may require peer review and will require cost information for setting a per diem rate. Payment for therapies may be authorized upon telephoned, FAXed, or written request by the physician, home infusion therapy provider, or pharmacist to the PA unit.