

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.*

Drug Requested: Immune Globulin Intravenous (IVIG) (immunodeficiency) (*Medical*)
{*Primary Immune Deficiency*}

DRUG INFORMATION: Complete all information below. If incomplete, authorization process will be delayed.

Circle applicable J Code: J1459 / J1556 / J1561 / J1566 / J1568 / J1569 / J1572

Drug Name/Form: _____ **Strength/Month:** _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Continuation of Therapy for Primary Immune Deficiency: Yes No

Medical notes and Labs values must be submitted to support each line checked on this request.

CLINICAL DIAGNOSIS: Check ALL applicable boxes below. Authorization process will be delayed if not completed.

- | | |
|---|---|
| <input type="checkbox"/> Severe combined immunodeficiency | <input type="checkbox"/> CD40 ligand deficiency (X-linked hyper-IgM syndrome) |
| <input type="checkbox"/> X-linked or autosomal recessive agammaglobulinemia | <input type="checkbox"/> Nuclear factor of κB essential modifier deficiency |
| <input type="checkbox"/> Common variable immunodeficiency | <input type="checkbox"/> Ataxia-telangiectasia |
| <input type="checkbox"/> Wiskott-Aldrich syndrome | <input type="checkbox"/> DiGeorge Syndrome |

The following diagnoses MUST meet ALL of the following additional criteria:

- | | |
|---|--|
| <input type="checkbox"/> IgG subclass deficiency | <input type="checkbox"/> Significant and clearly documented infectious morbidity such as recurrent pneumonia, frequent episodes of documented bacterial sinusitis (not isolated chronic sinusitis) |
| <input type="checkbox"/> IgA deficiency | <input type="checkbox"/> Allergy, anatomic defects, and other causes of increased infection susceptibility have been aggressively treated |
| <input type="checkbox"/> Specific antibody deficiency | <input type="checkbox"/> Failure of antimicrobial and anti-inflammatory therapies |
| <input type="checkbox"/> Transient hypogammaglobulinemia of infancy | |
| <input type="checkbox"/> Unspecified hypogammaglobulinemia | |

CLINICAL CRITERIA: Check one of the following below. The criteria MUST be met to qualify or authorization process will be delayed.

- IgG level <500 mg/dL (must submit copy of lab results from past 6 months) **AND** medical documentation showing recurrent infections and a concurrent diagnosis as above

AND

- Documented abnormal response to streptococcal vaccines (i.e., 4 fold increase in titers) to protein and polysaccharide antigens. (must submit copy of documentation of administration as well as streptococcal vaccine laboratory titer results at least 4 weeks after administration)

OR

(continued on next page)

FOR CONTINUATION OF THERAPY

- Documented history of humoral or combined immunodeficiency with claims for IVIG (*must submit documentation showing paid claims for IVIG*)

Medication being provided by (check applicable box below):

- Location/site of drug administration: _____
NPI or DEA # of administering location: _____

OR

- Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018