

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 the authorization process.

Drug Requested: **Immune Globulin Intravenous (IVIG) (Medical)**

DRUG INFORMATION: Complete all information below or 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:** _____

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

CLINICAL DIAGNOSIS: Check applicable diagnosis below to ensure authorization process will NOT be delayed.

- Autoimmune blistering disorders**
 - Pemphigus Vulgaris
 - Pemphigus foliaceus
 - Bullous pemphigoid
 - Mucous membrane pemphoid (cicatrical pemphigoid)
 - Epidermolysis bullosa acquisita
 - Immune Thrombocytopenic Purpura (For 1 treatment. If another treatment is warranted, must re-submit PA.)**
 - Platelet count <30, OR
 - Platelet count <50 w/ bleed, AND
 - Trial and failure of high dose steroid for 7 days
 - Chronic Inflammatory Demyelinating Neuropathy (three months only, submit status report)*
 - Ocular Myasthenia Gravis (five days only, submit status report)*
 - PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus Infections)
 - Prevention/Treatment of solid organ transplant rejection
 - Dermatomyositis
 - Hypogammaglobulinemia due to malignancy
 - Multiple Sclerosis/Relapsing-Remitting Form*
 - Kawasaki Syndrome
 - BMT/prevent complications
 - Polymyositis
 - Hyperbilirubinemia in the newborn
- Guillain-Barre Syndrome (For 1 treatment. If another treatment is warranted, must re-submit PA. Max of 2 treatments.)**
 - Defined by the following:
 - Bilateral & flaccid weakness of the limbs, &
 - Decreased or absent deep tendon reflexes in weak limbs, &
 - Monophasic illness pattern and interval between onset and nadir of weakness between 12h and 28 days and subsequent clinical plateau, &
 - Electrophysiological findings consistent with GBS, &
 - Cytoalbuminologic dissociation (elevation of CSF protein level above laboratory normal value &/or CSF total white count <50 cells/ μ L, &
 - Patient is non-ambulatory and 4 weeks or less have elapsed since onset of symptoms, &
 - Dose not to exceed 0.4g/kg/day x 5days.
 - HIV Infection/children**
 - In conjunction w/ AZT or other antiretroviral, to prevent mild to severe bacterial infection w/CD4+ counts < 200/uL
 - In conjunction w/ AZT, to prevent maternal transmission of HIV infection
 - HIV-positive children exposed to measles or live in a high-prevalence measles area
 - HIV-related ITP

(continued on next page)

CLINICAL CRITERIA: ALL boxes below MUST be checked to ensure authorization will NOT be delayed.

- Failed/contraindicated conventional therapy or rapidly progressive disease in which clinical response not yet achieved; will use IVIG until therapy takes effect (Autoimmune blistering disorders indication)
- Documentation that all standard therapies have failed or are contraindicated (Chronic Inflammatory Demyelinating Neuropathy, Ocular Myasthenia Gravis and Multiple Sclerosis/Relapsing-Remitting Form indications)
- Case is severe AND first and second lines of treatment have failed or not been tolerated (Polymyositis and Dermatomyositis indications)
- IgG level <500 mg/dL (must submit copy of lab results from past 6 months) AND medical documentation showing recurrent infections (hypogammaglobulinemia due to malignancy)

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