

# 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) -  
(Multifocal Motor Neuropathy - MMN) (Medical)**

**DRUG INFORMATION:** Complete all information below or authorization process will be delayed.

**Circle J Code that applies:**        **J1459 / J1556 / J1561 / J1566 / J1568 / J1569 / J1572**

**Drug 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/CRITERIA:** Check **one** of the applicable diagnoses below. Boxes **MUST** be checked to ensure the authorization process will **NOT** be delayed.

- Multifocal Motor Neuropathy (MMN): initial trial 4 weeks: (Please check one of the following):**
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> Asymmetric weakness that affects distal muscles   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Does the patient have upper motor neuron signs?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Does the nerve conduction studies confirm a demyelinating neuropathy is present (conduction block, slowing, or abnormal temporal dispersion in at least one nerve)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- OR**
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| <input type="checkbox"/> History and exam do not suggest upper motor neuron disease (no bulbar weakness, no upper motor neuron signs) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Labs show that GM-1 antibody titers are elevated   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- OR**
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| <input type="checkbox"/> Electrodiagnostic testing clinical presentation suggests MMN but the diagnosis remains uncertain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|
- Continued use of Ig after initial trial for MMN when the following criteria are met:**
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> Progress notes document an improvement in strength and function within three weeks of the start of the infusion period      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Continue need if during annual basis the dose was titrated or change in interval of therapy result in worsening of symptoms |                              |                             |

(signature on next page)

**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