OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 1-844-348-3720.** 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) {Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)}

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

Circle the J Code below that applies:

J1459 / J1556 / J1561 / J1566 / J1568 / J1569 / J1572 / J1559

Drug Form/Strength/Quantity: _____

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

Diagnosis: _____ **ICD Code:** _____

Dosing should be calculated using adjusted body weight if the patient's actual body weight is 20% higher than his or her ideal body weight (IBW).

(Adjusted body weight = IBW + 0.5 (actual body weight – IBW)

- **IBW (kg) for males = 50 + [2.3 (height in inches – 60)]**
- **IBW (kg) for females = 45.5 + [2.3 x (height in inches – 60)]**

It is recommended to attempt to decrease/wean the dose for renewal requests when improvement has occurred and subsequently stop IVIG therapy if improvement is sustained with a dose reduction (this does NOT apply to authorizations for primary immunodeficiency as long as immunoglobulin levels are maintained in the appropriate range.).

CLINICAL CRITERIA: Check applicable diagnosis below. Boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

For Initial Authorization: Treatment when ALL of the following required elements are met.

- ❑ Progressive or relapsing motor and/or sensory symptoms of more than one limb AND hyporeflexia or areflexia in affected limbs present for at least 2 months
- ❑ Electrophysiologic findings indicate demyelinating neuropathy (3 of the following 4 criteria are met per the American Academy of Neurology):
  - ❑ Partial conduction block* of ≥ 1 motor nerve
  - ❑ Reduced conduction velocity* of ≥ 2 motor nerves
  - ❑ Prolonged F-wave latencies* of ≥ 2 motor nerves or the absence of F-waves

(continued on next page)

- ❑ Other causes of demyelinating neuropathy have been excluded (from the European Federation of Neurological Societies and the Peripheral Nerve Society):
  - ❑ Borrelia burgdorferi infection (Lyme disease), diphtheria, drug or toxin exposure probably to have caused the neuropathy
  - ❑ Hereditary demyelinating neuropathy
  - ❑ Prominent sphincter disturbance
  - ❑ Diagnosis of multifocal motor neuropathy
  - ❑ IgM monoclonal gammopathy with high titre antibodies to myelin-associated glycoprotein
  - ❑ Other causes for a demyelinating neuropathy including POEMS syndrome, osteosclerotic myeloma, diabetic and non-diabetic lumbosacral radiculoplexus neuropathy, PNS lymphoma and amyloidosis.
- ❑ Testing to support diagnosis should be provided. This includes, but is not limited to, the following:
  - ❑ Cerebrospinal fluid (CSF) examination demonstrating elevated CSF protein with leukocyte count <10/mm3
  - ❑ MRI showing gadolinium enhancement and/or hypertrophy of the cauda equina, lumbosacral or cervical nerve roots, or the brachial or lumbosacral plexuses
  - ❑ Nerve biopsy showing unequivocal evidence of demyelination and/or remyelination by electron microscopy or teased fibre analysis

For Reauthorizations, significant improvement in clinical condition has been documented by an objective measurement such as the inflammatory neuropathy cause and treatment group (INCAT) sensory sum score; assessment of grip strength via a hand-held dynamometer (e.g., Jamar, Vigorimeter); or Medical Research Council (MRC) scales or other similar, validated neurological scales AND, when applicable, a reduction in the level of sensory loss should be noted.

- ❑ For long-term treatment, evidence that the dose has been periodically reduced or the treatment withdrawn, and the effects measured.

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy - PropriumRx**

(Signature on next page and MUST be attached to this request form.)

(Signature page MUST be included with this request form.)

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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 7/21/2016
REVISED/UPDATED: ~~9/22/2016; 12/11/2016; 6/8/2017; 7/24/2017; 5/18/2018;8/23/2018; 9/26/2018;~~ **12/31/2018**;