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) (Medical)

DRUG INFORMATON: Complete 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 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, **AND**
  - Decreased or absent deep tendon reflexes in weak limbs, **AND**
  - Monophasic illness pattern and interval between onset and nadir of weakness between 12h and 28 days and subsequent clinical plateau, **AND**
  - Electrophysiological findings consistent with GBS, **AND**
  - Cytoalbuminologic dissociation (elevation of CSF protein level above laboratory normal value &/or CSF total white count <50 cells/µL, **AND**
  - Patient is non-ambulatory and 4 weeks or less have elapsed since onset of symptoms, **AND**
  - 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

CLINICAL CRITERIA: **ALL** boxes below **MUST** be checked to qualify 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)

(continued 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: ~~8/1/2017;5/25/2018; 8/23/2018;~~ **10/8/2018**