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) (Medical)
{Primary Immune Deficiency}

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:** _____

❑ **Continuation of Therapy for Primary Immune Deficiency:** ❑ **Yes** ❑ **No**

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.).

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

CLINICAL DIAGNOSIS: Check **ALL** applicable boxes below or authorization will be delayed.

- ❑ Severe combined immunodeficiency
- ❑ X-linked or autosomal recessive agammaglobulinemia
- ❑ Common variable immunodeficiency
- ❑ Wiskott-Aldrich syndrome
- ❑ CD40 ligand deficiency (X-linked hyper-IgM syndrome)
- ❑ Nuclear factor of κβ essential modifier deficiency
- ❑ Ataxia-telangiectasia
- ❑ DiGeorge Syndrome

(continued on next page)

The following diagnoses MUST meet ALL of the following additional criteria:	
❑ IgG subclass deficiency ❑ IgA deficiency ❑ Specific antibody deficiency ❑ Transient hypogammaglobulinemia of infancy ❑ Unspecified hypogammaglobulinemia	❑ Significant and clearly documented infectious morbidity such as recurrent pneumonia, frequent episodes of documented bacterial sinusitis (not isolated chronic sinusitis) ❑ Allergy, anatomic defects, and other causes of increased infection susceptibility have been aggressively treated ❑ Failure of antimicrobial and anti-inflammatory therapies

CLINICAL CRITERIA: Check **one** of the following below. The criteria **MUST** be met to qualify to ensure authorization will **NOT** 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

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**

(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 #: _____

REVISED/UPDATED: ~~8/1/2017~~; ~~5/25/2018~~; ~~8/23/2018~~; ~~10/8/2018~~; **12/31/2018**