

OPTIMA HEALTH 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 1-844-723-2094.** 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) (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.

- | | |
|---|--|
| <input type="checkbox"/> Severe combined immunodeficiency | <input type="checkbox"/> CD40 ligand deficiency (X-linked hyper-IgM syndrome) |
| <input type="checkbox"/> X-linked or autosomal recessive agammaglobulinemia | <input type="checkbox"/> Nuclear factor of $\kappa\beta$ essential modifier deficiency |
| <input type="checkbox"/> Common variable immunodeficiency | <input type="checkbox"/> Ataxia-telangiectasia |
| <input type="checkbox"/> Wiskott-Aldrich syndrome | <input type="checkbox"/> DiGeorge Syndrome |

The following diagnoses **MUST** meet **ALL** of the following **additional** criteria:

(continued on next page)

<ul style="list-style-type: none"> <input type="checkbox"/> IgG subclass deficiency <input type="checkbox"/> IgA deficiency <input type="checkbox"/> Specific antibody deficiency <input type="checkbox"/> Transient hypogammaglobulinemia of infancy <input type="checkbox"/> Unspecified hypogammaglobulinemia 	<ul style="list-style-type: none"> <input type="checkbox"/> Significant and clearly documented infectious morbidity such as recurrent pneumonia, frequent episodes of documented bacterial sinusitis (not isolated chronic sinusitis) <input type="checkbox"/> Allergy, anatomic defects, and other causes of increased infection susceptibility have been aggressively treated <input type="checkbox"/> Failure of antimicrobial and anti-inflammatory therapies
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CLINICAL CRITERIA: Check one of the following below. The criteria **MUST** be met to qualify.

- 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**

****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 #: _____