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) (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**: _____

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 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 (cicatricial pemphigoid)
- ❑ Epidermolysis bullosa acquisita

❑ **Immune Thrombocytopenic Purpura** **(For ONE (1) treatment. If another treatment is warranted, must re-submit PA.)**

- ❑ Platelet count <30, OR
- ❑ Platelet count <50 w/ bleed, **AND**

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- ❑ 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 ONE (1) treatment. If another treatment is warranted, must re-submit PA. Maximum 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)

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- ❑ 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)

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; 12/31/2018;~~ **(Reformatted) 2/5/2019**;