

**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)  
(Multifocal Motor Neuropathy - MMN) (Medical)

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

**Circle J Code that applies:** J1459/J1556/J1561/ 1566/J1568/J1569/J1572

**Drug 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/CRITERIA:** Check **one** of the applicable diagnoses below. Boxes **MUST** be checked to qualify to ensure authorization process will **NOT** be delayed.

**Multifocal Motor Neuropathy (MMN): initial trial 4 weeks (Please check one of the following):**

- |  |  |
|--|--|
| <input type="checkbox"/> Asymmetric weakness that affects distal muscles   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Does the patient have upper motor neuron signs?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Does the nerve conduction studies confirm a demyelinating neuropathy is present (conduction block, slowing, or abnormal temporal dispersion in at least one nerve)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**OR**

- |   |  |
|---|--|
| <input type="checkbox"/> History and exam do not suggest upper motor neuron disease (no bulbar weakness, no upper motor neuron signs) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Labs show that GM-1 antibody titers are elevated   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**OR**

- |   |  |
|---|--|
| <input type="checkbox"/> Electrodiagnostic testing clinical presentation suggests MMN but the diagnosis remains uncertain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

(continued on next page)

- Continued use of Ig after initial trial for MMN when the following criteria are met:**
  - Progress notes document an improvement in strength and function within three weeks of the start of the infusion period  Yes  No
  - Continue need if during annual basis the dose was titrated or change in interval of therapy result in worsening of symptoms

**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.