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)
(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:** ______________

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/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)**:

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

OR

(continued on next page)

- ❑ History and exam do not suggest upper motor neuron disease (no bulbar weakness, no upper motor neuron signs) ❑ Yes ❑ No
- ❑ Labs show that GM-1 antibody titers are elevated ❑ Yes ❑ No

OR

- ❑ Electrodiagnostic testing clinical presentation suggests MMN but the diagnosis remains uncertain ❑ Yes ❑ No

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