OPTIMA HEALTH COMMUNITY 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:** _____

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**