OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICARE)

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 the authorization process**

Immune Globulin Intravenous (IVIG) (immunodeficiency SQ) (Medical)

Drug Requested: Check applicable box below. If **NOT** checked, authorization process will be delayed.	
❑ **Gammagard® (J1569)**	❑ **Gamunex-C® (J1561)**
❑ **Hizentra®** (Immune Globulin Subcutaneous (HUMAN) **(J1559)**	❑ **Hyqvia®** [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] **(J1575)**
❑ **Cuvitru (J3590)** **(NDCs: 0944-2850-07 / 0944-2850-05 / 0944-2850-03 / 0944-2850-01**)	

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.).

DRUG INFORMATION: Information **must** be completed or authorization process will be delayed.

Drug Name/Form: _____ **Strength/Month:** _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code:** _____

Medical notes and Labs values must be submitted to support each line checked on this request.*

CLINICAL DIAGNOSIS: Check box below that applies to ensure authorizaton will **NOT** be delayed.

- ❑ Severe combined immunodeficiency
- ❑ X-linked or autosomal recessive agammaglobulinemia
- ❑ Common variable immunodeficiency
- ❑ Wiskott-Aldrich syndrome
- ❑ CD40 ligand deficiency (X-linked hyper-IgM syndrome)
- ❑ Nuclear factor of κβ essential modifier deficiency
- ❑ Ataxia-telangiectasia
- ❑ DiGeorge Syndrome

The following diagnoses MUST meet ALL of the following additional criteria:	
❑ IgG subclass deficiency ❑ IgA deficiency ❑ Specific antibody deficiency ❑ Transient hypogammaglobulinemia of infancy ❑ Unspecified hypogammaglobulinemia	❑ Significant and clearly documented infectious morbidity such as recurrent pneumonia, frequent episodes of documented bacterial sinusitis (not isolated chronic sinusitis) ❑ Allergy, anatomic defects, and other causes of increased infection susceptibility have been aggressively treated ❑ Failure of antimicrobial and anti-inflammatory therapies

CLINICAL CRITERIA: Check applicable box(es) below. The criteria **MUST** be met to qualify to ensure authorization will **NOT** be delayed**.**

❑ 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 (ie, 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)

AND

❑ Patient cannot use IVIG due to poor venous access **AND** patient/primary caretaker able to self-administer **(should not be administered by a home health nurse beyond 1st month)**

❑ Submit chart notes documenting reason for patient being unable to self-administer and still requires subcutaneous immunoglobulin

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 #: _____

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