

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.	
<input type="checkbox"/> Gammagard® (J1569)	<input type="checkbox"/> Gamunex-C® (J1561)
<input type="checkbox"/> Hizentra® (Immune Globulin Subcutaneous (HUMAN) (J1559))	<input type="checkbox"/> Hyqvia® [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] (J1575)
<input type="checkbox"/> Cuvitru (J3590) (NDCs: 0944-2850-07 / 0944-2850-05 / 0944-2850-03 / 0944-2850-01)	

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 authorization will NOT be delayed.

- | | |
|--|---|
| <input type="checkbox"/> Severe combined immunodeficiency
<input type="checkbox"/> X-linked or autosomal recessive agammaglobulinemia
<input type="checkbox"/> Common variable immunodeficiency
<input type="checkbox"/> Wiskott-Aldrich syndrome | <input type="checkbox"/> CD40 ligand deficiency (X-linked hyper-IgM syndrome)
<input type="checkbox"/> Nuclear factor of $\kappa\beta$ essential modifier deficiency
<input type="checkbox"/> Ataxia-telangiectasia
<input type="checkbox"/> DiGeorge Syndrome |
|--|---|

The following diagnoses MUST meet ALL of the following additional criteria:	
<input type="checkbox"/> IgG subclass deficiency <input type="checkbox"/> IgA deficiency <input type="checkbox"/> Specific antibody deficiency <input type="checkbox"/> Transient hypogammaglobulinemia of infancy <input type="checkbox"/> Unspecified hypogammaglobulinemia	<input type="checkbox"/> Significant and clearly documented infectious morbidity such as recurrent pneumonia, frequent episodes of documented bacterial sinusitis (not isolated chronic sinusitis) <input type="checkbox"/> Allergy, anatomic defects, and other causes of increased infection susceptibility have been aggressively treated <input type="checkbox"/> 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 #: _____

REVISED/UPDATED: 8/1/2017; 4/6/2018; 5/25/2018; 8/23/2018; 10/8/2018