

OPTIMA HEALTH COMMUNITY 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)	

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 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 κβ essential modifier deficiency
<input type="checkbox"/> Ataxia-telangiectasia
<input type="checkbox"/> DiGeorge Syndrome |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

(continued on next page)

The following diagnoses MUST meet ALL of the following additional criteria:

- | | |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> IgG subclass deficiency | <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"/> IgA deficiency | <input type="checkbox"/> Allergy, anatomic defects, and other causes of increased infection susceptibility have been aggressively treated |
| <input type="checkbox"/> Specific antibody deficiency | <input type="checkbox"/> Failure of antimicrobial and anti-inflammatory therapies |
| <input type="checkbox"/> Transient hypogammaglobulinemia of infancy | |
| <input type="checkbox"/> Unspecified hypogammaglobulinemia | |

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; 12/31/2018; (Reformatted) 2/5/2019.