

# OPTIMA HEALTH COMMUNITY CARE

## 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.

**Drug Requested:**                    **Immune Globulin Intravenous (IVIG) (Medical)**

**DRUG INFORMATION:** Complete information below. If incomplete, authorization process will be delayed.

**Circle applicable J Code:**    **J1459 / J1556 / J1561 / J1566 / J1568 / J1569 / J1572**

**Drug Name/Form:** \_\_\_\_\_ **Strength/Month:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_ **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_

**\*Medical notes must be submitted to support each line checked on this request.\***

**CLINICAL DIAGNOSIS:** Check applicable diagnosis below. Incomplete information will delay authorization process.

- Autoimmune blistering disorders**
    - Pemphigus Vulgaris
    - Pemphigus foliaceus
    - Bullous pemphigoid
    - Mucous membrane pemphoid (cicatrical pemphigoid)
    - Epidermolysis bullosa acquisita
  - Immune Thrombocytopenic Purpura (For 1 treatment. If another treatment is warranted, must re-submit PA.)**
    - Platelet count <30, OR
    - Platelet count <50 w/ bleed, AND
    - Trial and failure of high dose steroid for 7 days
  - Chronic Inflammatory Demyelinating Neuropathy (three months only, submit status report)\*
  - Ocular Myasthenia Gravis (five days only, submit status report)\*
  - PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus Infections)
  - Prevention/Treatment of solid organ transplant rejection
  - Dermatomyositis
  - Hypogammaglobulinemia due to malignancy
  - Multiple Sclerosis/Relapsing-Remitting Form\*
  - Kawasaki Syndrome
  - BMT/prevent complications
  - Polymyositis
  - Hyperbilirubinemia in the newborn
- Guillain-Barre Syndrome (For 1 treatment. If another treatment is warranted, must re-submit PA. Max of 2 treatments.)**
  - Defined by the following:
    - Bilateral & flaccid weakness of the limbs, &
    - Decreased or absent deep tendon reflexes in weak limbs, &
    - Monophasic illness pattern and interval between onset and nadir of weakness between 12h and 28 days and subsequent clinical plateau, &
    - Electrophysiological findings consistent with GBS, &
    - Cytoalbuminologic dissociation (elevation of CSF protein level above laboratory normal value &/or CSF total white count <50 cells/ $\mu$ L, &
    - Patient is non-ambulatory and 4 weeks or less have elapsed since onset of symptoms, &
    - Dose not to exceed 0.4g/kg/day x 5days.
  - HIV Infection/children**
    - In conjunction w/ AZT or other antiretroviral, to prevent mild to severe bacterial infection w/CD4+ counts < 200/uL
    - In conjunction w/ AZT, to prevent maternal transmission of HIV infection
    - HIV-positive children exposed to measles or live in a high-prevalence measles area
    - HIV-related ITP

(continued on next page)

**CLINICAL CRITERIA:** ALL boxes below MUST be checked to qualify. If incomplete, authorization process will be delayed.

- Failed/contraindicated conventional therapy or rapidly progressive disease in which clinical response not yet achieved; will use IVIG until therapy takes effect (Autoimmune blistering disorders indication)
- Documentation that all standard therapies have failed or are contraindicated (Chronic Inflammatory Demyelinating Neuropathy, Ocular Myasthenia Gravis and Multiple Sclerosis/Relapsing-Remitting Form indications)
- Case is severe AND first and second lines of treatment have failed or not been tolerated (Polymyositis and Dermatomyositis indications)
- IgG level <500 mg/dL (must submit copy of lab results from past 6 months) AND medical documentation showing recurrent infections (hypogammaglobulinemia due to malignancy)

**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: 8/4/2017: 5/25/2018