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 INFORMATON*: *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/µL, **&**
  - ❑ 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

(signature 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)*****:**

❑ **Physician's office**

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