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) -**
(Multifocal Motor Neuropathy - MMN) (Medical)

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

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

Drug 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/CRITERIA: Check one of the applicable diagnoses below. Boxes MUST be checked to qualify. If incomplete, authorization process will be delayed.

❑ **Multifocal Motor Neuropathy (MMN): initial trial 4 weeks:** ***(Please check one of the following):***

- ❑ Asymmetric weakness that affects distal muscles ❑ Yes ❑ No
- ❑ Does the patient have upper motor neuron signs? ❑ Yes ❑ No
- ❑ Does the nerve conduction studies confirm a demyelinating neuropathy is present (conduction block, slowing, or abnormal temporal dispersion in at least one nerve)? ❑ Yes ❑ No

OR

- ❑ History and exam do not suggest upper motor neuron disease (no bulbar weakness, no upper motor neuron signs) ❑ Yes ❑ No
- ❑ Labs show that GM-1 antibody titers are elevated ❑ Yes ❑ No

OR

- ❑ Electrodiagnostic testing clinical presentation suggests MMN but the diagnosis remains uncertain ❑ Yes ❑ No

❑ **Continued use of Ig after initial trial for MMN when the following criteria are met:**

- ❑ Progress notes document an improvement in strength and function within three weeks of the start of the infusion period ❑ Yes ❑ No
- ❑ Continue need if during annual basis the dose was titrated or change in interval of therapy result in worsening of symptoms

(signature on next page)

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: ~~8/1/2017;~~ **5/25/2018**;