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)*:

- ❑ **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