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..***

Immune Globulin Intravenous (IVIG) (immunodeficiency SQ) (Medical)

Drug Requested: ***Check applicable box below. If NOT checked, authorization process will be delayed.***	
❑ **Gammagard® (J1569)**	❑ **Gamunex-C® (J1561)**
❑ **Hizentra®** (Immune Globulin Subcutaneous (HUMAN) **(J1559)**	❑ **Hyqvia®** [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] **(J1575)**
❑ **Cuvitru (J3590)** **(NDCs: 0944-2850-07 / 0944-2850-05 / 0944-2850-03 / 0944-2850-01)**	

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. Authorization process will be delayed if NOT checked.***

- ❑ Severe combined immunodeficiency
- ❑ X-linked or autosomal recessive agammaglobulinemia
- ❑ Common variable immunodeficiency
- ❑ Wiskott-Aldrich syndrome
- ❑ CD40 ligand deficiency (X-linked hyper-IgM syndrome)
- ❑ Nuclear factor of κβ essential modifier deficiency
- ❑ Ataxia-telangiectasia
- ❑ DiGeorge Syndrome

The following diagnoses MUST meet ALL of the following additional criteria:	
❑ IgG subclass deficiency ❑ IgA deficiency ❑ Specific antibody deficiency ❑ Transient hypogammaglobulinemia of infancy ❑ Unspecified hypogammaglobulinemia	❑ Significant and clearly documented infectious morbidity such as recurrent pneumonia, frequent episodes of documented bacterial sinusitis (not isolated chronic sinusitis) ❑ Allergy, anatomic defects, and other causes of increased infection susceptibility have been aggressively treated ❑ Failure of antimicrobial and anti-inflammatory therapies

(continued on next page)

CLINICAL CRITERIA: ***Check applicable box(es) below. The criteria MUST be met to qualify. If not checked, authorization process will 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**