OPTIMA HEALTH PLAN

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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 1-844-202-5034. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete information will delay authorization process.***

Drug Requested: **Immune Globulin Intravenous (IVIG) -**
(Multifocal Motor Neuropathy - MMN)

***DRUG INFORMATION:* Complete all information below or 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 to ensure authorization process will *NOT* be delayed.**

- ❑ **Multifocal Motor Neuropathy (MMN): initial trial 4 weeks:** ***(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 study 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

(continued 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: Briova SpecialtyRx**

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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 4/15/2013
REVISED/UPDATED: ~~6/30/2013; 8/19/2014; 10/31/2014; 5/23/2015; 12/30/2015~~; 1/29/2016; ~~8/18/2016; 9/22/2016; 12/11/2016; 7/24/2017;~~ **7/10/2018**