

# OPTIMA HEALTH PLAN

## 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. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.*

Will **SQ IVIG** therapy be administered by infusion facility?  Yes  No  
 If YES, fax form to Optima **Medical Services** at **1-844-202-5034**

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Will **SQ IVIG** therapy be self-administered by member?  Yes  No  
 If YES, fax form to: Optima **Pharmacy Department** at **1-800-750-9692**

**Check Drug Requested Below: Immune Globulin Intravenous (IVIG) (immunodeficiency SQ). If not checked, authorization process will be delayed.**

<input type="checkbox"/> <b>Gammagard® (J1569)</b>	<input type="checkbox"/> <b>Gamunex-C® (J1561)</b>
<input type="checkbox"/> <b>Hizentra®</b> (Immune Globulin Subcutaneous (HUMAN) (J1559))	<input type="checkbox"/> <b>Hyqvia®</b> [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] (J1575)
<input type="checkbox"/> <b>Cuvitru (J3590)</b> (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.

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| <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe combined immunodeficiency</li> <li><input type="checkbox"/> X-linked or autosomal recessive agammaglobulinemia</li> <li><input type="checkbox"/> Common variable immunodeficiency</li> <li><input type="checkbox"/> Wiskott-Aldrich syndrome</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> CD40 ligand deficiency (X-linked hyper-IgM syndrome)</li> <li><input type="checkbox"/> Nuclear factor of <math>\kappa\beta</math> essential modifier deficiency</li> <li><input type="checkbox"/> Ataxia-telangiectasia</li> <li><input type="checkbox"/> DiGeorge Syndrome</li> </ul> |
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**The following diagnoses MUST meet ALL of the following additional criteria:**

<ul style="list-style-type: none"> <li><input type="checkbox"/> IgG subclass deficiency</li> <li><input type="checkbox"/> IgA deficiency</li> <li><input type="checkbox"/> Specific antibody deficiency</li> <li><input type="checkbox"/> Transient hypogammaglobulinemia of infancy</li> <li><input type="checkbox"/> Unspecified hypogammaglobulinemia</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Significant and clearly documented infectious morbidity such as recurrent pneumonia, frequent episodes of documented bacterial sinusitis (not isolated chronic sinusitis)</li> <li><input type="checkbox"/> Allergy, anatomic defects, and other causes of increased infection susceptibility have been aggressively treated</li> <li><input type="checkbox"/> Failure of antimicrobial and anti-inflammatory therapies</li> </ul>
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**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 1<sup>st</sup> 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 #: \_\_\_\_\_

\*Approved by Pharmacy and Therapeutics Committee: 8/20/2015

REVISED/UPDATED: 9/29/2015; 12/28/2015; 3/24/16; 3/31/2016; 9/22/2016; 12/11/2016; 4/1/2017; 9/15/2017; 10/6/2017.