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; fax to 1-844-723-2094. 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) (immunodeficiency)**

{Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)}

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

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

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: Check applicable diagnosis below. Boxes MUST be checked to qualify. Incomplete information will delay authorization process.

Medical notes must be submitted to support each line checked on this request.

- ❑ **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP): initial trial 12 weeks: *(Check all that applies)*:**
  - ❑ No present of other polyneuropathies: IgM neuropathy, hereditary neuropathy, diabetic neuropathy
  - ❑ Does the patient have proximal muscle weakness or sensory dysfunction caused by neuropathy and nerve conduction studies (NCS) confirm there is electrodiagnostic evidence of demyelinating neuropathy in at least two (2) limbs
  - ❑ Distal muscle weakness and results of diagnostic testing meet a recognized set of diagnostic criteria as established by the American Academy of Neurology (AAN), or Inflammatory Neuropathy diagnostic tests meet):

- ❑ **Continued use of Ig after initial trial for CIDP when the following criteria are met:**
  - ❑ Clinically significant improvement in neurological symptoms is documented on physical examination. (If checked, please note improvements)
  - ❑ Has been on treatment for less than 1 year
  - ❑ Has been on treatment for at least 1 year and continued need is demonstrated by documentation that attempts on an annual basis to titrate the dose or the interval of therapy results in worsening symptoms. ***(If checked, please document dosage change and results below.)***

    _____

    _____

(continued on next page)

Medication being provided by (check box below that applies):

- ❑ **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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 7/21/2016
REVISED/UPDATED: ~~9/22/2016; 12/11/2016; 6/8/2017;~~ **7/24/2017**;