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. **Incomplete form will delay authorization process.**

Drug Requested: **Immune Globulin Intravenous (IVIG) (immunodeficiency) {Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)}**

DRUG INFORMATION: Complete information below or authorization will be delayed.

Circle the J Code below that applies:

J1459 / J1556 / J1561 / J1566 / J1568 / J1569 / J1572 / J1559

Drug Form/Strength/Quantity: _____

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

Diagnosis: _____ **ICD Code:** _____

Dosing should be calculated using adjusted body weight if the patient's actual body weight is 20% higher than his or her ideal body weight (IBW).

(Adjusted body weight = IBW + 0.5 (actual body weight – IBW)

- **IBW (kg) for males = 50 + [2.3 (height in inches – 60)]**
- **IBW (kg) for females = 45.5 + [2.3 x (height in inches – 60)]**

It is recommended to attempt to decrease/wean the dose for renewal requests when improvement has occurred and subsequently stop IVIG therapy if improvement is sustained with a dose reduction (this does NOT apply to authorizations for primary immunodeficiency as long as immunoglobulin levels are maintained in the appropriate range.).

CLINICAL CRITERIA: Check applicable diagnosis below. Boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

For Initial Authorization: **Treatment when ALL of the following required elements are met.**

- ❑ Progressive or relapsing motor and/or sensory symptoms of more than one limb **AND** hyporeflexia or areflexia in affected limbs present for at least 2 months
- ❑ Electrophysiologic findings indicate demyelinating neuropathy (3 of the following 4 criteria are met per the American Academy of Neurology):
  - ❑ Partial conduction block* of ≥ 1 motor nerve
  - ❑ Reduced conduction velocity* of ≥ 2 motor nerves
  - ❑ Prolonged F-wave latencies* of ≥ 2 motor nerves or the absence of F-waves
- ❑ Other causes of demyelinating neuropathy have been excluded (from the European Federation of Neurological Societies and the Peripheral Nerve Society):

(continued on next page)

- ❑ Borrelia burgdorferi infection (Lyme disease), diphtheria, drug or toxin exposure probably to have caused the neuropathy
- ❑ Hereditary demyelinating neuropathy
- ❑ Prominent sphincter disturbance
- ❑ Diagnosis of multifocal motor neuropathy
- ❑ IgM monoclonal gammopathy with high titre antibodies to myelin-associated glycoprotein
- ❑ Other causes for a demyelinating neuropathy including POEMS syndrome, osteosclerotic myeloma, diabetic and non-diabetic lumbosacral radiculoplexus neuropathy, PNS lymphoma and amyloidosis.

❑ Testing to support diagnosis should be provided. This includes, but is not limited to, the following:

- ❑ Cerebrospinal fluid (CSF) examination demonstrating elevated CSF protein with leukocyte count <10/mm3
- ❑ MRI showing gadolinium enhancement and/or hypertrophy of the cauda equina, lumbosacral or cervical nerve roots, or the brachial or lumbosacral plexuses
- ❑ Nerve biopsy showing unequivocal evidence of demyelination and/or remyelination by electron microscopy or teased fibre analysis

*** - Definitions from the American Academy of Neurology**

For Reauthorizations, significant improvement in clinical condition has been documented by an objective measurement such as the inflammatory neuropathy cause and treatment group (INCAT) sensory sum score; assessment of grip strength via a hand-held dynamometer (e.g., Jamar, Vigorimeter); or Medical Research Council (MRC) scales or other similar, validated neurological scales AND, when applicable, a reduction in the level of sensory loss should be noted.

❑ For long-term treatment, evidence that the dose has been periodically reduced or the treatment withdrawn, and the effects measured.

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

❑ **Location/site of drug administration:** _____

NPI or DEA # of administering location: _____

OR

❑ **Specialty Pharmacy - PropriumRx**

(**Signature on next page and MUST be attached with this request form.)**

(Signature page MUST be included with request form.)

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; 5/18/2018; 9/26/2018;~~ **12/31/2018**