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)**
{Primary Immune Deficiency}

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

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

Drug Name/Form: _____ **Strength/Month:** _____

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

Diagnosis: _____ **ICD Code:** _____

❑ **Continuation of Therapy for Primary Immune Deficiency:** ❑ **Yes** ❑ **No**

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

CLINICAL DIAGNOSIS: Check ALL applicable boxes below. Authorization process will be delayed if not completed.

- ❑ 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

CLINICAL CRITERIA: Check one of the following below. The criteria MUST be met to qualify.

- ❑ 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 (i.e., 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

(continued on next page)

FOR CONTINUATION OF THERAPY

- ❑ Documented history of humoral or combined immunodeficiency with claims for IVIG ***(must submit documentation showing paid claims for IVIG)***

Medication being provided by (check applicable box below):

- ❑ **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:** 7/16/2015
REVISED/UPDATED: ~~8/26/2015~~; ~~1/29/2016~~; ~~8/18/2016; 9/22/2016~~; ~~12/11/2016;~~ **7/27/2017**;