

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) -
(Multifocal Motor Neuropathy - MMN)**

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

- Multifocal Motor Neuropathy (MMN): initial trial 4 weeks: (Check one of the following):**
- | | | |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> Asymmetric weakness that affects distal muscles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Does the patient have upper motor neuron signs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Does the nerve conduction studies confirm a demyelinating neuropathy is present (conduction block, slowing, or abnormal temporal dispersion in at least one nerve)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- OR**
- | | | |
|---|------------------------------|-----------------------------|
| <input type="checkbox"/> History and exam do not suggest upper motor neuron disease (no bulbar weakness, no upper motor neuron signs) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Labs show that GM-1 antibody titers are elevated | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- OR**
- | | | |
|---|------------------------------|-----------------------------|
| <input type="checkbox"/> Electrodiagnostic testing clinical presentation suggests MMN but the diagnosis remains uncertain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|
- Continued use of Ig after initial trial for MMN when the following criteria are met:**
- | | | |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> Progress notes document an improvement in strength and function within three weeks of the start of the infusion period | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> 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):

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:** 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