

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.**

Immune Globulin Intravenous (IVIG) (immunodeficiency SQ) (Medical)

Drug Requested: Check applicable box below. If **NOT** checked, authorization could be delayed.

<input type="checkbox"/> Gammagard® (J1569)	<input type="checkbox"/> Gamunex-C® (J1561)
<input type="checkbox"/> Hizentra® (Immune Globulin Subcutaneous (HUMAN) (J1559)	<input type="checkbox"/> Hyqvia® [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] (J1575)
<input type="checkbox"/> Cuvitru (J3590) (NDCs: 0944-2850-07 / 0944-2850-05 / 0944-2850-03 / 0944-2850-01)	

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.).

DRUG INFORMATION: Information below **must** be completed to ensure authorization will **NOT** be delayed.

Drug Name/Form: _____ Strength/Month: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Height: _____ inches Weight: _____ kg

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

CLINICAL DIAGNOSIS: Check box that applies. Authorization will be delayed if **NOT** checked.

- | | |
|---|--|
| <input type="checkbox"/> Severe combined immunodeficiency | <input type="checkbox"/> CD40 ligand deficiency (X-linked hyper-IgM syndrome) |
| <input type="checkbox"/> X-linked or autosomal recessive agammaglobulinemia | <input type="checkbox"/> Nuclear factor of $\kappa\beta$ essential modifier deficiency |
| <input type="checkbox"/> Common variable immunodeficiency | <input type="checkbox"/> Ataxia-telangiectasia |
| <input type="checkbox"/> Wiskott-Aldrich syndrome | <input type="checkbox"/> DiGeorge Syndrome |

(continued on next page)

The following diagnoses **MUST** meet **ALL** of the following **additional** criteria:

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

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 1st month**)
- Submit chart notes documenting reason for patient being unable to self-administer and still requires subcutaneous immunoglobulin

Medication being provided by: Please check applicable box(es) below.

- Location/site of drug administration: _____
NPI or DEA # of administering location: _____

OR

- Specialty Pharmacy - PropriumRx

(Continued on next page; Signature page **must** be attached to this request form.)

(Signature page **MUST** be included with request.)

****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; 1/3/2017; 4/1/2017; 7/24/2017; 4/10/2018; 5/21/2018; 11/5/2018;
11/30/2018