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. 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.***

❑ **Will SQ IVIG therapy be *administered by infusion facility*?** ❑ **Yes** ❑ **No**

***If YES, fax form to Optima* Medical Services at 1-844-723-2094)**

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❑ **Will SQ IVIG therapy be *self-administered by member*?** ❑ **Yes** ❑ **No**

***If YES, fax form to*: *Optima* Pharmacy Department at 1-800-750-9692)**

Check Drug Requested Below*: *Immune Globulin Intravenous (IVIG) (immunodeficiency SQ). If not checked, authorization process will be delayed.	
❑ **Gammagard® (J1569)**	❑ **Gamunex-C® (J1561)**
❑ **Hizentra®** (Immune Globulin Subcutaneous (HUMAN) **(J1559)**	❑ **Hyqvia®** [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] **(J1575)**
❑ **Cuvitru (J3590)** **(NDCs: 0944-2850-07 / 0944-2850-05 / 0944-2850-03 / 0944-2850-01)**	

***DRUG INFORMATION:** Information must be completed or authorization process will be delayed.*

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

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

Diagnosis: _____ **ICD Code:** _____

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

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

- ❑ 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

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***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

*****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**