

AvMed

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 1-877-535-1391. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is not complete, correct, or legible, authorization can be delayed.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Additional indications may be covered at the discretion of the health plan.

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

Drug Requested: Check applicable box below. If not checked, authorization could be delayed.	
PREFERRED	
<input type="checkbox"/> Bivigam [®] [Immune Globulin Intravenous (Human), 10% Liquid] (J1556)	<input type="checkbox"/> Gammaked [™] [Immune Globulin Injection (Human), 10% Caprylate/Chromatography Purified] (J1561)
<input type="checkbox"/> Flebogamma [®] DIF [Human Normal Immunoglobulin (IVIg)] (J1572)	<input type="checkbox"/> Gamunex [®] - C [Immune Globulin Injection (Human), 10% Caprylate/Chromatography Purified] (J1561)
<input type="checkbox"/> Gammagard [®] Liquid [Immune Globulin Infusion (Human), 10% Solution, for intravenous and subcutaneous administration] (J1569)	<input type="checkbox"/> Octagam [®] [Immune Globulin Intravenous (Human) liquid preparation] (J1568)
<input type="checkbox"/> Gammagard [®] S/D [Immune Globulin Intravenous (Human) Solvent/Detergent Treated (Freeze-Dried Concentrate)] (J1566)	<input type="checkbox"/> Privigen [®] [Immune Globulin Intravenous (Human), 10% Liquid] (J1459)
NON-PREFERRED	
<input type="checkbox"/> Hyqvia [®] [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] (J1575) (AG)*	<input type="checkbox"/> Panzyga [®] [Immune Globulin Intravenous (Human) – ifas 10% Liquid Preparation] (J1576)

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MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____
Member AvMed #: _____ Date of Birth: _____
Prescriber Name: _____
Prescriber Signature: _____ Date: _____
Office Contact Name: _____
Phone Number: _____ Fax Number: _____
NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____
Dosing Schedule: _____ Length of Therapy: _____
Diagnosis: _____ ICD Code, if applicable: _____
Height: _____ inches Weight (last 30 days): _____

Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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 = $IBW + 0.5 (\text{actual body weight} - IBW)$)
- IBW (kg) for males = $50 + [2.3 (\text{height in inches} - 60)]$
 - IBW (kg) for females = $45.5 + [2.3 \times (\text{height in inches} - 60)]$

***IMPORTANT* - If recommended adjusted body weight is not accepted, a PARTIAL approval will be granted.**

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 (PID)** as long as immunoglobulin levels are maintained in the appropriate range).

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: Initial coverage will be provided for 12 months and may be renewed annually thereafter

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- Member is 18 years of age or older
- Prescribed by or in consultation with a specialist for CIDP
- Member has progressive or relapsing and remitting CIDP for > 2 months (**submit documentation**)
- Member was determined to have Probable or Definite CIDP according to EFNS/PNS 2010
- Member has decreased or absent deep tendon reflexes in upper or lower limbs
- Electrodiagnostic testing indicating demyelination must meet **TWO** of the following:
 - Partial motor conduction block in at least 2 motor nerves or in 1 nerve plus one other demyelination criterion listed here in at least 1 other nerve
 - Distal CMAP duration increase in at least 1 nerve plus one other demyelination criterion listed here in at least 1 other nerve
 - Abnormal temporal dispersion conduction must be present in at least 2 motor nerves
 - Reduced motor conduction velocity in at least 2 motor nerves
 - Prolonged distal motor latency in at least 2 motor nerves
 - Absent F wave in at least 2 motor nerves plus one other demyelination criterion listed here in at least 1 other nerve
 - Prolonged F wave latency in at least 2 motor nerves
 - $\geq 30\%$ amplitude reduction of the proximal negative peak CMAP relative to distal, excluding the posterior tibial nerve, if distal negative peak CMAP $\geq 20\%$ of LLN, in two nerves, or in one nerve + ≥ 1 other demyelinating parameter in ≥ 1 other nerve
- Member has a baseline CIDP Disease Activity Status (CDAS) score ≥ 2 (**submit documentation**)
- Members baseline in strength/weakness has been documented using an objective clinical measuring tool (e.g., INCAT, Medical Research Council (MRC) muscle strength (**submit documentation**))
- Requested medication will **NOT** be used as maintenance therapy in combination with immunoglobulin or intravenous efgartigimod
- Members must have tried and failed at least **ONE** corticosteroid for at least 3 months **unless** member has a contraindication or intolerance to the use of corticosteroids (**failure is defined objective measurement such as INCAT score did not show improvement while on a steroid**)
 - Has member tried and failed a corticosteroid (e.g., oral prednisolone, IV methylprednisolone) for at least 3 months? Yes No
 - If **YES**, provide the following information:
 - Drug Name/Form: _____
 - Strength: _____ Length of Therapy: _____
 - Dosing Schedule: _____
- Does member have any contraindications or intolerances to corticosteroids? Yes No
- If **YES**, please provide details: _____

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- For Hyqvia® & Panzyga® Requests:** Member must have a 90-day trial & failure of **three (3)** preferred IVIG products (**documentation of treatment failure must be submitted with request**)

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

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

OR

- Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed Health Plan's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****