OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY 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: **Actimmune**® (interferon gamma-1b) **(J9216)** ***(Medical)***

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: ____

Dosing Schedule: ________________________________ **Length of Therapy:** ____________________

Diagnosis: ____ **ICD Code:** __________________________

HEIGHT: ________________ **cm/in (circle)** **OR** **WEIGHT:** ______________ **kg/lb (circle)**

Injections should be administered subcutaneously three times weekly.
Length of therapy: one year. A vial of ACTIMMUNE® is suitable for a single-use only.

CLIMICAL CRITERIA:

CLINICAL CRITERIA: All boxes must be checked to ensure the authorization process will NOT be delayed. (Chronic Granulomatous Disease and severe malignant osteoporosis: 50mcg/m² for patients whose body surface area is greater than 0.5m² and 1.5 mcg/kg/dose for patients whose body surface area is equal to or less than 0.5m²)

- ***Patient Diagnosis - Chronic granulomatous disease (CGD):***

- Physician is an: ❑ Infectious Disease Specialist ❑ Hematologist

AND

- Diagnostic results (***Submit results with request***):
  - ❑ Nitroblue tetrazolium test (Negative)

    OR
  - ❑ Dihydrorhodamine test (DHR+ neutrophils < 95%)

    OR
  - ❑ Genetic analysis or immunoblot positive for p22phox p40phox, p47phox, p67phox, or gp91phox

AND

- Documented trial and failure of:
  - ❑ Trimethoprim/sulfamethoxazole (5mg/kg daily, divided)

    AND
  - ❑ Itraconazole (200mg/day for patients > 50 kg)

- ***Patient Diagnosis - Severe malignant osteoporosis:***

- Physician is an: ❑ Endocrinologist ❑ Other (Please specify)______________

AND

- Diagnostic results (***Submit results with request***):
  - Documentation of ***ALL*** of the following:
    - ❑ X-ray or increased liver function tests
    - ❑ Decreased RBC and WBC counts
    - ❑ Growth retardation
    - ❑ Deafness/sensorineural hearing loss

AND

❑ **Submit baseline testing of CBC with differential, platelets, LFTs, electrolytes, BUN, creatinine, and urinalysis**

(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 #: ____

REVISED/UPDATED: 7/1/2018