# OPTIMA HEALTH FAMILY CARE

## (MEDICAID)

### 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.**

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

**DRUG INFORMATION:** Information **must** be completed below**.** Injections should be administered subcutaneously **three times weekly**. **Length of therapy**: **ONE YEAR.** A vial of ACTIMMUNE® is suitable for a single use only.

**Drug Form/Strength:** _____

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

**Diagnosis:** _____ **ICD Code:** _____

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

**CLINICAL CRITERIA:** Check **all** that apply. **All** boxes **must** be checked to qualify. Incomplete information will delay the authorization process.) (Chronic Granulomatous Disease and severe malignant osteopetrosis: 50mcg/$m^2$ for patients whose body surface area is greater than 0.5$m^2$ and 1.5 mcg/kg/dose for patients whose body surface area is equal to or less than 0.5$m^2$):

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

- **Physician is**: ❑ **Infectious Disease Specialist** **OR** ❑ **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 osteopetrosis:**

- **Physician is**: ❑ **Endocrinologist** ❑ **Other (Please specify)** _____

**(continued on next page)**

**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

**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:** ~~8/1/2017;~~ ~~8/14/2018;~~ ~~10/8/2018;~~ **(Reformatted) 2/4/2019**;