

OPTIMA HEALTH COMMUNITY 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 1-844-348-3720.** 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/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:** **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: 8/4/2017; 8/14/2018; 10/8/2018; (Reformatted) 2/4/2019