OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 1-844-348-3720**. 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/m^2 for patients whose body surface area is greater than 0.5m^2 and 1.5 mcg/kg/dose for patients whose body surface area is equal to or less than 0.5m^2):

- **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 osteopetrosis:**

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

    AND

(continued on next page)

- 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**;