OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA HEALTH 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 1-800-750-9692**. 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 will be delayed.**

Drug Requested: Actimmune® (interferon gamma-1b) **(SQ) (Pharmacy Only)**

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

Drug Form/Strength/Quantity: ____

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

Diagnosis: __________________________________ **ICD Code, if applicable**: _______________

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

- A vial of ACTIMMUNE® is suitable for a single-use only.
- **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.

  Injections should be administered subcutaneously three times weekly.

  Length of therapy: ONE YEAR.

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

Patient Diagnosis (select below ALL that apply):

- ❑ **Chronic granulomatous disease (CGD)**
  - Physician is: ❑ 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

(Continued on next page)

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

AND

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

❑ **Severe malignant osteopetrosis**

- Physician is: ❑ 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**

Medication being provided by a 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 #: ____

Approved by Pharmacy and Therapeutics Committee: 4/16/2015
REVISED/UPDATED: 5/11/2019