

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.*

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

DRUG INFORMATION: *Complete information below. If incomplete, authorization process will be delayed.*

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

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

CLINICAL CRITERIA: *Check applicable diagnosis below. Boxes **MUST** be checked to qualify. Incomplete information will delay authorization process.*

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

PATIENT DIAGNOSIS (select **ALL** the applicable diagnoses below):

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**
- 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

(signature on next page)

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 #: _____

*REVISED/UPDATED: 8/26/2017