OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION 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 1-844-202-5034. 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 to ensure authorization process will NOT be delayed.. (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 to ensure authorization will NOT be delayed. 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
  - 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

(continued on next page)

- ❑ **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: Briova SpecialtyRx**

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: ~~5/26/2015; 12/30/2015; 1/29/2016; 922/2016; 12/11/2016; 2/7/2017; 9/11/2017;~~ **10/4/2017**;