OPTIMA HEALTH PLAN

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.***

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.***
- **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 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

(continued on next page)

- ❑ **Submit baseline testing of CBC with differential, platelets, LFTs, electrolytes, BUN, creatinine, and urinalysis**

Medication being provided by a 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~~; ~~12/24/2015~~; ~~9/22/2016~~; ~~12/11/2016~~; ~~9/11/2017~~; **10/6/2017**