

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 1-844-723-2094. 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/m² for patients whose body surface area is greater than 0.5m² and 1.5 mcg/kg/dose for patients whose body surface area is equal to or less than 0.5m²):

• **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

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

(continued on next page)

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 #: _____

*Approved by Pharmacy and Therapeutics Committee: 4/16/2015

REVISED/UPDATED: 5/26/2015; 12/30/2015; 1/29/2016; 9/22/2016; 12/11/2016; 2/7/2017; 8/1/2017