

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/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. **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: 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; 12/24/2015; 9/22/2016; 12/11/2016; 7/31/2017;