Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Actimmune® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic granulomatous disease (CGD)
❑ Severe malignant osteopetrosis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Document patient's height: _____
Document patient's weight: _____ lbs/kg
Does the patient have baseline testing of complete blood count (CBC) with differential, platelets, liver function tests (LFTs), electrolytes, blood urea nitrogen (BUN), creatinine, and urinalysis? ❑ **Yes** ❑ **No**
Submission of baseline testing of complete blood count (CBC) with differential, platelets, liver function tests (LFTs), electrolytes, blood urea nitrogen (BUN), creatinine, and urinalysis required

For chronic granulomatous disease (CGD), also answer the following:

Select the prescribing physician's specialty:
❑ Infectious disease ❑ Hematology

Select if the patient has the following diagnostic results:
❑ Nitroblue tetrazolium test (negative)
❑ Dihydrorhodamine test (DHR+ neutrophils less than 95%)
❑ Genetic analysis or immunoblot positive for p22phox p40phox, p47phox, p67phox, or gp91phox
Submission of diagnostic result(s) required

Select if there is documentation the patient has had trial and failure to any of the following:
❑ Trimethoprim/sulfamethoxazole (5 mg/kg daily, divided)
❑ Itraconazole (200mg/day for patients greater than 50 kg)

For severe malignant osteopetrosis, also answer the following:

Select the prescribing physician's specialty:
❑ Endocrinologist ❑ Other (please specify): _____

Does the patient have any diagnostic results? ❑ **Yes** ❑ **No**
Submission of diagnostic result(s) required

Select if there is documentation of the following:
❑ X-ray or increased liver function tests
❑ Decreased red blood cell (RBC) and white blood cells (WBC) counts
❑ Growth retardation
❑ Deafness/sensorineural hearing loss

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Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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