PHARMACY COVERAGE GUIDELINE

ACTIMMUNE® (interferon gamma-1b)
Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Criteria:

➢ **Criteria for initial therapy:** Actimmune (interferon gamma-1b) is considered ***medically necessary*** and will be approved when **ALL** the following criteria are met:

1. Prescriber is a physician specializing in the individual's diagnosis or is in consultation with an endocrinologist or immunologist depending on the indication

2. Individual has a confirmed diagnosis of **ONE** of the following:
    a. Chronic Granulomatous Disease (CGD) with molecular genetic test identifying a gene-related mutation linked to chronic granulomatous disease (see Definitions section)

    b. Malignant osteopetrosis with **ONE** of the following:
        i. Radiographic (X-ray) imaging demonstrating skeletal features related to osteopetrosis

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.

ii. Molecular genetic test identifying a gene-related mutation linked to malignant osteopetrosis (see Definitions section)

3. **If available:** Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

4. There are **NO** FDA-label contraindications such as known hypersensitivity to interferon gamma, *E. coli* derived products, or any component of the product

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request): Actimmune (interferon gamma-1b)** and/or generic equivalent (if available) is considered ***medically necessary*** and will be approved when **ALL** the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Individual continues to be seen by a physician specializing in the individual's diagnosis or is in consultation with an endocrinologist or immunologist depending on the indication

2. Individual's condition has responded while on therapy with response defined as the following:
   a. For Chronic Granulomatous Disease (CGD), individual has reduced frequency and severity of infections
   b. For Malignant osteopetrosis, **ONE** of the following:
      i. Hematologic recovery (improvement in platelets and hemoglobin)
      ii. Increase in leukocyte superoxide activity
      iii. Decrease in trabecular bone volume

3. Individual has been adherent with the medication

4. **If available:** Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

5. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use, such as:
   a. Hypersensitivity to interferon gamma, *E. coli* derived products, or any component of the product
   b. Neutropenia
   c. Thrombocytopenia
   d. Decreased mental status, gait disturbances, and dizziness

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.

PHARMACY COVERAGE GUIDELINE

ACTIMMUNE® (interferon gamma-1b) Generic Equivalent (if available)

1. **Off-Label Use of Non-Cancer Medications**
2. **Off-Label Use of Cancer Medications**

Benefit Type:

Pharmacy Benefit:
ACTIMMUNE

Medical Benefit:
ACTIMMUNE

Coding:

HCPCS: J9216

Description:

Actimmune (interferon gamma-1b) is an interferon gamma indicated for: reducing the frequency and severity of serious infections associated with Chronic Granulomatous Disease (CGD) and delaying time to disease progression in patients with severe, malignant osteopetrosis (SMO).

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting
MedWatch Forms for FDA Safety Reporting | FDA

Genetic Mutations of Chronic Granulomatous Disease: *CYBA, CYBB, NCF1, NCF2, NCF4*

Genetic Mutations of osteopetrosis: *CAII, CLCN7, IKBLG, ITGB3, LRP5, OSTM1, PLEKHM1, SNX10, TCIRG1, TNFSF11, and TNFRSF11A*

Resources:

Actimmune (interferon gamma-1b) injection, solution prescribing information, revised by Horizon Therapeutics USA, Inc. October 2020 at DailyMed, http://dailymed.nlm.nih.gov. Accessed January 13, 2025.

Manolagas SC. Normal skeletal development and regulation of bone formation and resorption. In: UpToDate, Rosen CJ, Rubinow K (Eds). UpToDate, Waltham, MA.: Available at http://uptodate.com. Topic last updated January 29, 2024. Accessed January 13, 2025.

Marciano BE, Zerbe CS, Holland SM. Chronic granulomatous disease: Treatment and prognosis: In: UpToDate, Orange JS, TePas E (Eds). UpToDate, Waltham, MA.: Available at http://uptodate.com. Topic last updated January 30, 2023. Accessed January 13, 2025.

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.

Tangye SG, Al-Herz W, Bousfiha A, et al. Human inborn errors of immunity: 2022 update on the classification from the International Union of Immunological Societies Expert Committee*. J Clin Immunol.* 2022; 42:1473-1507.

Wu CC, Econs MJ, DiMeglio LA, et al. Diagnosis and management of osteopetrosis: consensus guidelines from the Osteopetrosis Working Group. *J Clin Endocrinol Metab.* 2017; 103: 311-3123.

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.