Updated: 10/2020
DMMA Approved: 10/2020

Request for Prior Authorization for Actimmune (interferon gamma-1b)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Actimmune (interferon gamma-1b) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Actimmune (interferon gamma-1b) Prior Authorization Criteria:

For all requests for Actimmune (interferon gamma-1b) all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must provide documentation of the following:
  - Complete blood counts, differential and platelet counts
  - Renal and liver function tests
  - Urinalysis

Coverage may be provided with a diagnosis of Severe, Malignant Osteopetrosis (SMO) and the following criteria is met:

- Must be prescribed by an orthopedic surgeon, hematologist, endocrinologist, or in consultation with one of these specialists.
- Diagnosis must be confirmed by radiological evidence
- Must provide clinical rationale explaining why hematopoietic stem cell transplantation (HSCT) would be inappropriate for the member or physician attestation that member is on wait list for transplantation
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to a corticosteroid
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - Documentation that member is tolerating and responding to treatment
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided to reduce the frequency and severity of infections in members with a diagnosis of Chronic Granulomatous Disease (CGD) and the following criteria is met:

- Diagnosis must be confirmed via DHR or gene testing.
- Member must be receiving concurrent antibiotic therapy and antifungal therapy
- Must be prescribed by a hematologist, immunologist, infectious disease physician, or in consultation with one of these specialists
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**

  - Documentation that member is tolerating and responding to treatment
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

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ACTIMMUNE (INTERFERON GAMMA-1B) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: _____ ICD10 Code(s): _____

Is Actimmune being prescribed in consultation with a specialist? ☐ Yes ☐ No **If Yes**, what is their specialty? _____
Is the member's complete blood cell count, urinalysis, liver, and renal function tests provided? ☐ Yes ☐ No

For **Severe, Maligant Osteopetrosis**:
Does the member have radiological evidence confirming the diagnosis? ☐ Yes ☐ No
Is the member on the wait list for hematopoietic stem cell transplantation? ☐ Yes ☐ No
If No, please provide a clinical rationale: _____
_____
_____
_____
_____

For **Chronic Granulomatous Disease:**
Does the member have genetic testing or flow cytometric dihydrorhodamine neutrophil respiratory burst assay confirming the diagnosis? ☐ Yes ☐ No
Is the member receiving concurrent antibiotic and antifungal therapy? ☐ Yes ☐ No

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ACTIMMUNE (INTERFERON GAMMA-1B)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member tolerating and responding to treatment? ☐ Yes ☐ No
Please describe: _____
_____
_____
_____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date