Updated: 05/2021
PARP Approved: 06/2021

Prior Authorization Criteria

Actimmune (interferon gamma-1b)

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.

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

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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health℠ It's Wholecare.

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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 Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Gateway ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, 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:	ICD Code:

For Severe, Malignant Osteopetrosis (SMO):

- Has the diagnosis been confirmed by radiological evidence? ☐ Yes ☐ No
- Have corticosteroids been tried? ☐ Yes ☐ No
- Is the member on the wait list for stem cell transplant? ☐ Yes ☐ No (please explain below)

For Chronic Granulomatous Disease:

- How was the diagnosis confirmed? ☐ Genetic testing ☐ DHR
- Is the member receiving concurrent antibiotic and antifungal therapy? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Is the member responding to treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date