

## lt's Wholecare.

## 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 <u>diagnosis</u> of **Severe**, **Malignant Osteopetrosis** (**SMO**) and the following criteria is met:

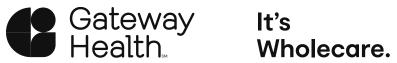
- Must be prescribed by an orthopedic surgeon, hematologist, endocrinologist, or in consultation with one of these specialists.
- Diagnosis must be confirmed by radiological evidence
- Must provide clinical rationale explaining why hematopoietic stem cell transplantation (HSCT) would be inappropriate 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 <u>diagnosis</u> 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.



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 <sup>SM</sup> 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:			ax:	
MEMBER INFORMATION				
Member Name: DOB:				
Gateway ID: Member weight: Height:				
REQUESTED DRUG INFORMATION				
		Strength:		
		Quantity:	Refills:	
Is the member currently receiving requested medication? Yes No Date Medication Initiated:				
Billing Information				
This medication will be billed: at a pharmacy <b>OR</b> medically, JCODE:				
Place of Service: Hospital Provider's office Member's home Other				
Place of Service Information				
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)	
		10		
REAUTHORIZATION				
Is the member responding to treatment? Yes No				
SUPPORTING INFORMATION or CLINICAL RATIONALE				
Prescribing Provider Signature Date				
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