# SENTARA COMMUNITY PLAN
# (MEDICAID)

## MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions:** **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

**Drug Requested: Actimmune®** (interferon gamma-1b) **(J9216) (Medical)**

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member Sentara #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**DEA OR NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete. (Injections should be administered subcutaneously **three times weekly**. A vial of ACTIMMUNE® is suitable for a single use only.)

**Length of therapy: ONE YEAR**

**Drug Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code:** _____

**HEIGHT:** _____ **cm/in (circle)** **OR** **WEIGHT**: _____ **kg/lb (circle)**

**(Chronic Granulomatous Disease and severe malignant osteopetrosis:**
50mcg/$m^2$ for patients whose body surface area is greater than 0.5$m^2$ and 1.5 mcg/kg/dose for patients whose body surface area is equal to or less than 0.5$m^2$).

❑ Standard Reviews. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis - Chronic granulomatous disease (CGD):**

**Physician is**: ❑ **Infectious Disease Specialist** **OR** ❑ **Hematologist**

**(Continued on next page)**

**AND**

- ❑ Diagnostic results:
  - ❑ Nitroblue tetrazolium test (Negative)

**OR**

  - ❑ Dihydrorhodamine test (DHR+ neutrophils < 95%)

**OR**

  - ❑ Genetic analysis or immunoblot positive for p22phox p40phox, p47phox, p67phox, or gp91phox

**AND**

- ❑ Documented trial and failure of:
  - ❑ Trimethoprim/sulfamethoxazole (5mg/kg daily, divided)

**AND**

  - ❑ Itraconazole (200mg/day for patients > 50 kg)

## ❑ Diagnosis - Severe malignant osteopetrosis:

**Physician is**: ❑ **Endocrinologist** **OR** ❑ **Other (Please specify)** _____

**AND**

- ❑ Diagnostic results:
  - ❑ Documentation of all of the following:
    - ❑ X-ray or increased liver function tests
    - ❑ Decreased RBC and WBC counts
    - ❑ Growth retardation
    - ❑ Deafness/sensorineural hearing loss

**AND**

- ❑ Submit baseline testing of CBC with differential, platelets, LFTs, electrolytes, BUN, creatinine, and urinalysis

## Medication being provided by (check box below that applies):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Sentara Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara defines a request as urgent where applying the routine decision timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****



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