OPTIMA HEALTH PLAN

PHARMACY/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 1-844-668-1550**. 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**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

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

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 0.5m^2 and 1.5 mcg/kg/dose for patients whose body surface area is equal to or less than 0.5m^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 an:** ❑ **Infectious Disease Specialist** **OR** ❑ **Hematologist**

AND

❑ Diagnostic results:

❑ Nitroblue tetrazolium test (Negative)

OR

❑ Dihydrorhodamine test (DHR+ neutrophils < 95%)

(Continued on next page)

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 an**: ❑ **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 Optima Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Optima 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.

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

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.*

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 4/16/2015
REVISED/UPDATED: ~~5/26/2015~~; ~~12/30/2015~~; ~~1/29/2016~~; ~~922/2016~~; ~~12/11/2016~~; ~~2/7/2017~~; ~~8/1/2017~~; ~~(Reformatted)~~ ~~3/14/2019~~; ~~7/6/2019~~; **9/16/2019**