SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. 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 will be delayed.**

Drug Requested: Actimmune® (interferon gamma-1b) **(SQ) (Pharmacy Only)**

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.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

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

- A vial of ACTIMMUNE® is suitable for a single-use only.
- **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.

Injections should be administered subcutaneously three times weekly.

Length of therapy: ONE YEAR

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.

Patient Diagnosis (select below ALL that apply):

(Continued on next page)

❑ **Chronic granulomatous disease (CGD)**

- Physician is: ❑ Infectious Disease Specialist ❑ Hematologist

AND

- Diagnostic results (**Submit results with request**):
  - ❑ 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)

❑ **Severe malignant osteopetrosis**

- Physician is: ❑ Endocrinologist ❑ Other (please specify) _____

AND

- Diagnostic results (**Submit results with request**):
- 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 a Specialty Pharmacy - PropriumRx

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.

***Approved by Pharmacy and Therapeutics Committee**: 4/16/2015
REVISED/UPDATED: ~~5/11/2019;09/20/22;~~ **11/8/2023**