AvMed

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 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

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

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

Member Name: _____

Member AvMed #: _____ **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:** _____

Weight: _____ **Date:** _____

- **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.

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

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Patient Diagnosis (select below all diagnoses that apply)**:**

❑ Chronic granulomatous disease (CGD)

- Physician is **(check box below that applies)**:

❑ 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 **(check box below that applies)**:

❑ Endocrinologist	❑ Other (Please specify): _____

AND

- Diagnostic results (**Submit results with request**):
- Documentation of all of the following:
  - ❑ X-ray or increased liver function tests; **AND**
  - ❑ Decreased RBC and WBC counts; **AND**
  - ❑ Growth retardation; **AND**
  - ❑ Deafness/sensorineural hearing loss;

AND

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

Medication being provided by 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.*