

Pharmacy Prior Authorization Form

Last Reviewed: Nov. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Actimmune[®] (interferon gamma 1 b) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Actimmune 100 mcg injection

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of Actimmune requires:

- Diagnosis of chronic granulomatous disease or malignant osteoporosis
- Dosage of 1.5 mcg/kg/dose three times weekly for patients with BSA < 0.5 m³ or 50 mcg/ m³ three times weekly for patients ≥ 0.5 m³

Diagnosis:

Chronic granulomatous disease

Malignant osteoporosis

Other: _____ Rationale for use: _____

Patient's body surface area (BSA): _____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX