

Pharmacy Prior Authorization Form

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): _____

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects

2. The number of doses available under a dose restriction for the prescription drug:
- a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
- a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

***** All fields must be complete and legible for Prior Authorization Review***
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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**