Actimmune® (interferon gamma-1b)

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

1. Date: Click or tap to enter a date.	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: / / to / /

Not to exceed 6 months for initial therapy. Additional therapy may be approved for up to 1 year.

Question	Yes	No	Comments/Notes
12. Please select the diagnosis of the patient: ☐ Chronic Granulomatous Disease ☐ Benign Osteopetrosis ☐ Intermediate Osteopetrosis ☐ Osteopetrosis Congenita (Severe, Malignant) ☐ Osteopetrosis Tarda ☐ Marble Bone Disease ☐ Other* (Please list): _____			*Please include clinical studies or articles to support the use of Actimmune® if you listed a non-FDA approved indication.
13. If the diagnosis is for Chronic Granulomatous Disease, has the diagnosis been confirmed with a nitroblue-tetrazolium (NBT) or another recognized test to confirm the diagnosis?			
14. If the diagnosis is for Chronic Granulomatous Disease, is the patient being treated with prophylactic antibiotics?			
15. If the diagnosis is for Osteopetrosis has the diagnosis been confirmed by X-ray or biopsy?			
16. Has the patient received previous Actimmune® therapy and you are requesting that the patient continues with therapy?			
17. If 'yes' to 16, has the patient experienced a reduction in the number of infections since initiating therapy **OR** experienced no disease progression if the diagnosis is for Osteopetrosis?			**Clinical documentation is required.**
18. Source of Medication (please select one): ☐ Accredo ☐ Physician (Bill by J-code) ☐ Approved Home Health			If no selection is made, Accredo will be used
19. Physicians Signature: _____			

PEHP USE ONLY	
Site of approval: Accredo, Approved Home Health, or Medical	**J-code**: J9216

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