

Sterling Retiree Rx Prior Authorization Form

ACTIMMUNE (Interferon gamma-1b)

Coverage Criteria / Required Medical Information

To reduce frequency and severity of serious infections associated with Chronic Granulomatous Disease or delaying time to disease progression in patients with severe malignant osteopetrosis.

Patient has no history of myelosuppression; complete blood count within normal limits; platelet count within normal limits; **and** LFTs within normal limits.

Monitoring of complete blood count, platelet count, and LFTs every 3 months is required.

Coverage Duration: 3 months

Exclusion Criteria

Hypersensitivity to E.coli-derived products and/or interferon gamma.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

ACTIMMUNE	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing		Strength/Dosage	
Formulary Alternative(s) Attempted?	Yes:		No:
Please List Alternative Formulary Drugs			

Comments	
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Physician Signature: _____

Fax Form to 1-866-481-3704