AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Actimmune	Page:	1 of 2
Effective Date:	3/6/2025	Last Review Date:	2/2025

Applies to:	☒Illinois	☐Florida	☒New Jersey
	☒Maryland	☒Florida Kids	☒Pennsylvania Kids
	☐Michigan	☒ Virginia	☒Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Actimmune under the patient's prescription drug benefit.

Description:

A. FDA-Approved Indications
   1. Actimmune is indicated for reducing the frequency and severity of serious infections associated with chronic granulomatous disease
   2. Actimmune is indicated for delaying time to disease progression in patients with severe, malignant osteopetrosis

B. Compendial Uses
   1. Mycosis fungoides/Sezary syndrome

All other indications are considered experimental/investigational and not medically necessary

Applicable Drug List:

Actimmune

Policy/Guideline:

Criteria for Initial Approval:

I. Authorization may be granted for the indications listed when the following criteria are met:

A. Chronic Granulomatous Disease
   - Request is to reduce the frequency and severity of infections associated with chronic granulomatous disease
   - Medication is prescribed by or in consultation with an immunologist or prescriber who specializes in the management of Chronic Granulomatous Disease

B. Severe, Malignant Osteopetrosis
   - Request is to delay time to disease progression in patients with severe, malignant osteopetrosis
   - Medication is prescribed by or in consultation with an endocrinologist

C. Mycosis Fungoides/Sezary Syndrome
   - For treatment of mycosis fungoides or Sezary syndrome
   - Medication is prescribed by or in consultation with a hematologist or oncologist

Criteria for Continuation of Therapy

II. Authorization may be granted for continuation of treatment when the following criteria are met:

A. For Chronic Granulomatous Disease
- Request is to reduce the frequency and severity of infections associated with chronic granulomatous disease
- Medication is prescribed by or in consultation with an immunologist or prescriber who specializes in the management of Chronic Granulomatous Disease
- The patient has been experiencing a benefit from therapy as evidenced by disease stability or disease improvement

B. For severe, Malignant Osteopetrosis
- Request is to delay time to disease progression in patients with severe, malignant osteopetrosis
- Medication is prescribed by or in consultation with an endocrinologist
- The patient has been experiencing a benefit from therapy as evidenced by disease stability or disease improvement

C. For Mycosis Fungoides/Sezary Syndrome
- Request is for treatment of mycosis fungoides or Sezary syndrome
- Medication is prescribed by or in consultation with a hematologist or oncologist
- The patient has been experiencing a benefit from therapy as evidenced by disease stability or disease improvement

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

1. Actimmune [package insert]. Deerfield, IL: Horizon Therapeutics USA, Inc.; March 2021.
2. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. Available at: https://www.nccn.org. Accessed August 8, 2024.