Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Actimmune (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Actimmune (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

ACTIMMUNE (interferon gamma-1b)

Other, Please specify: _____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Does the patient meet one of the following? A) Body surface area (BSA) is less than or equal to 0.5 meters squared AND the prescribed dose does not exceed 1.5 mcg per kg, or B) Body surface area (BSA) is greater than 0.5 meters squared AND the prescribed dose does not exceed 50 mcg per meter squared Y N

   Please provide patient's BSA, weight, and prescribed dose:
   _____

   [If no, no further questions.]

2. Does the patient have a diagnosis of chronic granulomatous Y N

disease (CGD)?

[If no, skip to question 6.]

3. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 5.]

4. Has the patient demonstrated an overall reduction in the incidence and/or severity of serious infections since starting Actimmune? Y N

   [No further questions.]

5. Is the patient also receiving prophylactic antimicrobials (such as itraconazole and trimethoprim/sulfamethoxazole)? Y N

   [If yes, skip to question 9.]

   [If no, no further questions.]

6. Does the patient have a diagnosis of severe, malignant osteopetrosis? Y N

   [If no, no further questions.]

7. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 10.]

8. Is the patient responding to therapy as demonstrated by having no disease progression? Y N

   [No further questions.]

9. Is the patient at least 1 year old? Y N

   [If no, no further questions.]

10. Is Actimmune being prescribed by, or in consultation with an appropriate specialist based on the condition being treated? Y N

    List specialty:
    _____

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date