

The following policy is for medication that falls under the Medicare Part D benefit only.

Prior Authorization Group: ACTIMMUNE Policy

Drug(s): ACTIMMUNE (interferon gamma-1b)

Covered Uses: Chronic Granulomatous Disease (CGD) and osteopetrosis. All criteria in "other criteria" section must be met for coverage.

Required Medical Information: Supporting documentation including prescription history, complete blood count (CBC) with differential. Medical history

Age Restrictions: N/A

Prescriber Restrictions: N/A

Other Criteria:

Documented diagnosis of CGD and continued frequent serious infectious episodes while receiving prophylactic antibiotics

OR

Diagnosis of severe, malignant osteopetrosis and documentation of at least 3 of the following:

- Previous therapy with intravenous antibiotics,
- anemia,
- thrombocytopenia,
- splenomegaly,
- blindness, optic atrophy, hearing loss greater than 20 dB,
- chronic osteomyelitis.

Continued therapy will be considered at a maximum of 6 month intervals based on demonstrated response identified by reduction in serious infections requiring intravenous antibiotics (CGD), reduction in hospitalizations due to serious infections (CGD), increase in hemoglobin and platelet counts (osteopetrosis), no more than 50dB decrease in hearing and no evidence of progressive optic atrophy (osteopetrosis), no evidence of a serious bacterial infection requiring antibiotics (osteopetrosis).

Exclusion Criteria:

- Actimmune is not covered for any indication other than (CGD) or osteopetrosis.
- Not covered for idiopathic pulmonary fibrosis (IPF) and renal cell carcinoma (RCC).
- Doses greater than or less than the recommended dose of 50mcg/m² are not covered.

Coverage Duration: 3 months initial approval. 6 months for extension of therapy