Commercial/Healthcare Exchange PA Criteria

Effective: August 1st, 2019

Prior Authorization: Actimmune (Interferon Gamma-1B) Prior Authorization

Products Affected: Actimmune (Interferon Gamma-1B) injection

Medication Description: Interferon gamma participates in immunoregulation by enhancing the oxidative metabolism of macrophages; it also enhances antibody dependent cellular cytotoxicity, activates natural killer cells, and has a role in the expression of Fc receptors and major histocompatibility antigens

Covered Uses:
Chronic granulomatous disease: Reducing frequency and severity of serious infections associated with chronic granulomatous disease
Malignant osteopetrosis (severe): Delay time to disease progression in patients with severe, malignant osteopetrosis

Exclusion Criteria: N/A

Required Medical Information: Diagnosis

Age Restrictions:
Chronic granulomatous disease: 1 year and older
Malignant osteopetrosis (severe): 1 month and older

Prescriber Restrictions: N/A

Coverage Duration: 12 months

Other Criteria:
1. Patient has a diagnosis of Chronic Granulomatous Disease or Malignant Osteoporosis

References:

1. Actimmune (interferon gamma-1b) solution for injection [prescribing information]. Roswell, GA: HZNP USA; June 2016.
2. Actimmune. Drug Facts and Comparisons. eFacts [online]. 2003. Available from Wolters Kluwer Health, Inc. Accessed June 9, 2016.

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	6/9/2016
2	Update	Adoption of EH Policy by CCI	All	8/1/2019
3	Update	Align criteria with EH updates: removed exclusion criteria, added age restrictions, extended coverage duration	Exclusion Criteria Age Restrictions Coverage Duration	1/1/2020