



## Commercial/Healthcare Exchange PA Criteria

*Effective: August 1<sup>st</sup>, 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.

Last Res. December 27<sup>th</sup>, 2019



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**Policy Revision history**

<b>Rev #</b>	<b>Type of Change</b>	<b>Summary of Change</b>	<b>Sections Affected</b>	<b>Date</b>
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