Prescriber Criteria Form

Actimmune 2026 PA Fax 562-A v1 010126.docx
Actimmune (interferon gamma-1b)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Actimmune (interferon gamma-1b).

Drug Name:
Actimmune (interferon gamma-1b)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed to reduce the frequency and severity of serious infections associated with Chronic Granulomatous Disease? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed to delay time to disease progression in a patient with severe, malignant osteopetrosis? [If yes, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for the treatment of any of the following: A) mycosis fungoides, B) Sezary syndrome?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____