blue of california

interferon gamma-1b solution for subcutaneous injection (ACTIMMUNE)

Diagnoses Considered for Coverage:

- Chronic Granulomatous Disease
- Osteopetrosis
- Mycosis fungoides or Sezary Syndrome

Coverage Criteria:

1. **For diagnosis of Chronic Granulomatous Disease or Severe Malignant Osteopetrosis, approve if:**
   - One of the following:
     - For BSA > 0.5 m^2 patient: Dose does not exceed 50 mcg/m^2/dose given three times per week, **or**
     - For BSA ≤ 0.5 m^2 patient: Dose does not exceed 1.5 mcg/kg/dose given three times per week.

2. **For diagnosis of Mycosis fungoides/Sezary syndrome, approve if:**
   - Dose does not exceed 50 mcg/m^2/dose given three times per week.

Coverage Duration: one year

Effective Date: 09/27/2023