Actimmune
PRIOR APPROVAL REQUEST

Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER / PATIENT INFORMATION

Cardholder Name: ______________________________ / _____ / ____________________________________
First MI Last

Patient Name: ______________________________ / _____ / ____________________________________
First MI Last

Patient Address: ____
Street City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F _____

R | | | | | | | |
Cardholder Identification Number

PHYSICIAN COMPLETES

ACTIMMUNE (Interferon Gamma-1B)

NOTE: Form must be completed in its **entirety** for processing

1. What is the patient's **diagnosis?**

❑ Chronic granulomatous disease:

a. Is there a serious infection associated? ❑Yes ❑No

b. Has the patient been receiving **Actimmune** therapy for at least **6 months** continuously, excluding samples?

❑**NO** – this would be the **INITIATION** of Actimmune therapy
❑**YES** – this would be the **CONTINUATION of therapy**, please answer **the following** question:
i. Has there been a decrease in the number of serious infections? ❑Yes ❑No

❑ Osteopetrosis:

a. Is the patient's osteopetrosis considered to be severe malignant? ❑Yes ❑No
❑ Other Diagnosis (please specify) ____

2. Will complete blood counts, differential and platelet counts be completed prior to initiation of therapy and every three months during treatment? ❑Yes ❑No

3. Will renal and liver function tests be completed prior to initiation and every three months in adults or monthly for patients < 1 year of age during treatment? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification.

Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer,

______________________________ (_____) ________________ (_____) ________________
Physician Name (Print Clearly) Phone Fax

______________________________ ________________ ________ ________
Street Address City State Zip

________________ ______________________________ ______ / ______ / ______
Prescriber's NPI Physician Signature Date