P.O. Box 30192
Salt Lake City, UT 84120-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Actimmune™
(Interferon Gamma-1B)

Therapeutic use: To reduce the frequency and severity of serious infections associated with chronic granulomatous disease and for delaying the time to disease progression in patients with severe, malignant osteopetrosis.

Quantity Limit: N/A

Authorization Period: 12 months

Patient's name _____

Patient's ID# ☐☐☐☐☐☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐☐☐☐☐☐ _____

Provider's name_____

Provider's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Provider's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the patient diagnosed with chronic granulomatous disease?	❑ Yes	❑ No
2.	Is the patient diagnosed with severe, malignant osteopetrosis?	❑ Yes	❑ No
Absolute or relative contraindications to Actimmune include: • Hypersensitivity to Actimmune or *E. coli* derived products • Pre-existing cardiac disease • Diagnosis of seizure disorder or central nervous system dysfunction			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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