UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2018 P 1001-6
Program	Prior Authorization/Notification
Medication	Actimmune® (interferon gamma-1b)
P&T Approval Date	02/2013, 8/2014, 8/2015, 6/2016, 6/2017, 6/2018
Effective Date	9/1/2018; Oxford only: 9/1/2018

1. Background:

Actimmune (interferon gamma-1b) is a biologic response modifier indicated for the treatment of chronic granulomatous disease to reduce the frequency and severity of serious infections. It is also indicated in the treatment of severe, malignant osteopetrosis to delay the time to progression.[1] The National Cancer Comprehensive Network (NCCN) recommends use of Actimmune in mycosis fungoides (MF) and Sézary syndrome (SS).[2]

Coverage Information:

Members will be required to meet the criteria below for coverage.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria:

A. <u>Patients less than 19 years of age</u>

1. Actimmune will be approved based on **<u>both</u>** of the following criteria:

a. Patient has oncology diagnosis

-AND-

b. Patient is less than 19 years of age

Authorization will be issued for 12 months.

B. <u>Chronic Granulomatous Disease (CGD)</u>

1. Authorization

a. **Actimmune** will be approved based on the following criterion:

(1) Diagnosis of chronic granulomatous disease

Authorization will be issued for 12 months.

2. Reauthorization

a. **Actimmune** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Actimmune

Authorization will be issued for 12 months.

C. Osteopetrosis

1. Initial Authorization

a. **Actimmune** will be approved based on the following criterion:

(1) Diagnosis of severe, malignant osteopetrosis

Authorization will be issued for 12 months.

2. Reauthorization

a. **Actimmune** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Actimmune

Authorization will be issued for 12 months.

D. Non-Hodgkin's Lymphoma (NHL) (off-label)

1. Initial Authorization

a. **Actimmune** will be approved based on the following criterion:

(1) Patient has **one** of the following diagnoses:

(a) Mycosis fungoides (MF)
(b) Sézary syndrome (SS)

Authorization will be issued for 12 months.

2. Reauthorization

a. **Actimmune** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Actimmune

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Supply limits may apply.

4. References:

1. Actimmune [Package Insert]. Roswell, GA: HZNP USA Inc.; May 2017.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed April 19, 2018.

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Change Control	
8/2014	Annual review with no changes to Coverage Criteria. Updated formatting and References.
8/2015	Annual review. Added oncology indication requirement to age 19 criteria. Increased authorization and reauthorization from 6 months to 12 months for all indications. Updated references.
6/2016	Annual review. Added reauthorization criteria for CGD. Updated formatting and references.
6/2017	Annual review. Updated references.
6/2018	Annual review. Updated references.