



Actimmune

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____

Referring Provider Info: Same as Requesting Provider

Name: _____ NPI#: _____
Fax: _____ Phone: _____

Referring Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ NPI#: _____
Fax: _____ Phone: _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office

Drug Information:

Strength/Measure _____ Units ml Gm mg ea Un
Directions(sig) _____ Route of administration _____
Dosing frequency _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Actimmune SGM – 07/2021.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076
Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com

Criteria Questions:

1. What is the diagnosis?
 - Chronic granulomatous disease (CGD)
 - Severe, malignant osteopetrosis
 - Mycosis fungoides (MF) [type of cutaneous T-cell lymphoma]
 - Sezary syndrome (SS) [type of cutaneous T-cell lymphoma]
 - Other _____
2. What is the ICD-10 code? _____
3. Is the request for continuation of therapy with the requested medication? Yes No *If No, skip to #5*
4. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? Yes No *No further questions*
5. *If diagnosis is chronic granulomatous disease (CGD)*, will the requested medication be used to reduce the frequency and severity of infection associated with the patient's disease? Yes No
6. *If diagnosis is severe, malignant osteopetrosis*, will the requested medication be used to delay time to disease progression? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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