Prescriber Criteria Form

Actimmune 2024 PA Fax 562-A v1 010124.docx
Actimmune (interferon gamma-1b)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark a**t 1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Actimmune (interferon gamma-1b).

Drug Name:
Actimmune (interferon gamma-1b)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have any of the following diagnoses: A) chronic granulomatous disease, B) severe, malignant osteopetrosis, C) mycosis fungoides, D) Sezary syndrome?	Yes	No

Comments: ______________________________

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: ________________________________ Date:____________________