



Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Actimmune

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

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

1. Which drug is being prescribed? Actimmune Dose: _____ Frequency: _____
 Other _____
2. What is the diagnosis?
 Chronic granulomatous
 Malignant osteopetrosis
 Other _____
3. What is the ICD9? _____
4. Is the patient currently receiving Actimmune? Yes No

Complete the section designated for the patient's diagnosis

Section A: Chronic granulomatous disease

4. Has chronic granulomatous disease been confirmed with neutrophil function test followed by either immunoblot or genotyping? Yes No
5. Has the patient demonstrated reduction in frequency and severity of serious infection associated with CGD? Yes No

Section B: Malignant osteopetrosis

6. Is the patient experiencing disease progression while on Actimmune? Yes No

****NOTE: We can NOT make a decision without a copy of lab results - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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