



Physician's Prior Authorization Questionnaire
Actimmune® (Interferon Gamma 1B)

Patient:

ID#:

DOB:

Patient Address:

Interferon Gamma 1B (Actimmune®) is covered under certain medical conditions. Please complete the following to assist us in making a determination of this patient's eligibility for coverage for this therapy.

1. Interferon Gamma 1B – (code J9216) is being prescribed for the following medical diagnosis:

[ ] Chronic Granulomatous disease of childhood

[ ] Renal Carcinoma

[ ] Chronic Myelocytic Leukemia

[ ] Other, please specify: \_\_\_\_\_

2. Will this medication be administered in physician's office? [ ] Yes [ ] No

OR

3. Will patient purchase at a participating pharmacy and self-administer? [ ] Yes [ ] No

4. How long do you anticipate this therapy to last? \_\_\_\_\_

If patient administered, Actimmune® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please Print Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx