Specialty Guideline Management

ACTIMMUNE (Interferon gamma-1b)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
   1. Reducing the frequency and severity of serious infections associated with Chronic Granulomatous Disease
   2. Delaying time to disease progression in patients with severe, malignant osteopetrosis

B. Compendial Uses
   1. Mycosis Fungoides/Sezary Syndrome
   2. Atopic dermatitis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Chronic Granulomatous Disease
Authorization of 24 months may be granted for the treatment of chronic granulomatous disease.

B. Severe, Malignant Osteopetrosis
Authorization of 24 months may be granted for treatment of severe, malignant osteopetrosis.

C. Mycosis Fungoides/Sezary Syndrome
Authorization of 12 months may be granted for the treatment of mycosis fungoides or Sezary syndrome.

D. Atopic Dermatitis
Authorization of 12 months may be granted for the treatment of atopic dermatitis.
.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Actimmune [package insert]. Roswell, GA: Vidara Therapeutics Inc.; August 2015.
2. The NCCN Drugs & Biologics Compendium™ © 2015 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed October 17, 2016.
3. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed October 17, 2016.
4. CVS Caremark Clinical Programs Review: Focus on Dermatology; November 2010.