ACTICTION CRITERIA

Requests for Actimmune (interferon gamma-1b) may be approved for the treatment of any of the following conditions:

I. Chronic granulomatous disease; OR
II. Severe malignant osteopetrosis; OR
III. Mycosis fungoides, including Sézary syndrome (NCCN 2A).

Requests for Actimmune (interferon gamma-1b) may not be approved for the following:

I. All other indications not included above, including but not limited to:
   A. Advanced ovarian or primary peritoneal cancer; OR
   B. Atopic dermatitis; OR
   C. Brain tumors; OR
   D. Chronic hepatitis C; OR
   E. Friedreich’s ataxia; OR
   F. Idiopathic pulmonary fibrosis; OR
   G. Invasive fungal infection, post-transplantation (for example, after hematopoietic stem cell or solid organ transplantation); OR
   H. Metastatic renal cell cancer; OR
   I. Pulmonary tuberculosis.
This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

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