

POLICY NAME

Actimmune (interferon gamma-1b)

POLICY #

2412P

Criteria

Criteria for Coverage for Chronic Granulomatous Disease

- ☐ 1.1 Diagnosis of Chronic Granulomatous Disease
- ☐ 1.2 Approval Time: 12 months

Criteria for Coverage for Malignant Osteopetrosis

- ☐ 2.1 Diagnosis of Malignant Osteopetrosis
- ☐ 2.2 Approval Time: 12 months

Criteria for Coverage if Used within a Chemotherapy Regimen

- ☐ 3.1 Requests should be reviewed by eviCore
- ☐ 3.2 See Oncology Regimen Review policy CPT Codes HCPCS Codes J9216 Injection, interferon, gamma-1b, 3 million units