

### ALPHA-1 PROTEINASE INHIBITORS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Alpha-1 Proteinase Inhibitors** are available on the DHS Pharmacy Services website at  
<http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # of pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

#### CLINICAL INFORMATION

<b>Medication requested:</b> <input type="checkbox"/> Aralast NP <input type="checkbox"/> Glassia** <input type="checkbox"/> Prolastin-C <input type="checkbox"/> Zemaira	Quantity:	vials / milligrams
Directions:	Weight:	lbs / kg    Refills:
Diagnosis:	DX code (required):	
**Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? <input type="checkbox"/> Diplomat Specialty <input type="checkbox"/> Walgreen's Specialty		

#### All Requests

1. What is the beneficiary's smoking status? <input type="checkbox"/> non-smoker <input type="checkbox"/> former smoker <input type="checkbox"/> current smoker	<i>Submit supporting chart documentation</i>
2. Is the beneficiary IgA deficient with antibodies against IgA?	<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No
3. If prescriber is NOT a pulmonologist, is the requested medication being prescribed in consultation with a pulmonologist?	<input type="checkbox"/> Yes – <i>Submit documentation of consultation.</i> <input type="checkbox"/> No or not applicable

#### Initial Requests

1. Does the beneficiary have documentation of a baseline (pre-treatment) alpha-1 antitrypsin serum level?	<input type="checkbox"/> Yes – <i>Submit documentation of testing method and results.</i> <input type="checkbox"/> No
2. Does the beneficiary have clinically evident emphysema secondary to severe alpha-1 antitrypsin deficiency (AATD)?	<input type="checkbox"/> Yes – <i>Submit documentation of results of spirometry and other diagnostic tests.</i> <input type="checkbox"/> No
3. Does the beneficiary have one of the following high-risk AATD phenotypes? <u>Check the applicable phenotype.</u> <input type="checkbox"/> Pi*ZZ <input type="checkbox"/> Pi*Z(null) <input type="checkbox"/> Pi*(null,null) <input type="checkbox"/> Pi*SZ	<input type="checkbox"/> Yes – <i>Submit documentation of laboratory analysis and results.</i> <input type="checkbox"/> No

#### Renewal Requests

1. Have the beneficiary's signs and symptoms of emphysema associated with AATD improved or stabilized since starting therapy?	<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No
2. Does the beneficiary have results of recent spirometry testing since starting therapy?	<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No
3. Did the beneficiary experience a decrease in frequency, duration, or severity of pulmonary exacerbations of emphysema?	<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No

#### **PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b>	<b>Date:</b>
------------------------------	--------------

**Confidentiality Notice:** The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.