

Pharmacy

PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Aralast[®] / Glassia[®] / Prolastin[®] / Zemaira[®]

(alpha₁-proteinase inhibitor (human))

URGENT (life threatening)

Non-Urgent (Standard Review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

| | |
|---------------|-------------|
| Member Name: | Member No.: |
| DOB: | Gender: |
| Member's PCP: | |

Provider Information

| | |
|----------------------|-----------------|
| Provider Name: | |
| Office Contact Name: | Provider Phone: |
| Provider NPI: | Provider Fax: |
| Provider Address: | |

Provider Signature

Date

PRODUCT INFORMATION

Aralast NP 0.5g vial 1g vial
 Glassia 1g vial
 Prolastin 0.5g vial 1g vial
 Zemaira 1g vial

Dosage: _____

Start Date: _____

BILLING INFORMATION

Place of administration:

Self-administered
 Provider's Office
 Outpatient Infusion Center
 Center Name: _____
 Home Infusion
 Agency Name: _____

Billing Options:

Physician buy and bill
 Preferred Specialty Vendor
 Other: _____

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for alpha₁-proteinase inhibitor (human) requires the following to certify:

Patient must:

- have a diagnosis of congenital alpha₁-antitrypsin deficiency **with** clinically evident emphysema
- have a predicted FEV₁ value between 30 and 65%
- have a serum AAT level less than 11 µmol/L (less than 60 mg/dL)
- be a non-smoker

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for alpha₁-proteinase inhibitor (human) requires the following information to certify:

A. What is the patient's diagnosis?

a. Congenital alpha₁-antitrypsin deficiency

b. Other: _____

Rationale for use: _____

B. Does the patient have emphysema?

a. Yes

b. No – Rationale for use: _____

C. What is the patient's predicted FEV₁?

Date: _____

Value: _____ %

D. What is the patient's serum AAT level?

Date: _____

Value: _____ µmol/L, or
_____ mg/dL

E. Is the patient currently a smoker?

a. No

b. Yes – Rationale for use: _____

*** All fields must be complete and legible for Prior Authorization Review***

Please fax this request to: (877)974-4411 toll free or (616)942-8206

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX