

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

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

(alpha₁-proteinase inhibitor (human))

 URGENT (life threatening)

 Non-Urgent (Standard Review)

A claim involving "urgent care" applies when the 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

 Glassia 1g/50 mL solution
 Prolastin 0.5g vial 1g vial
 Zemaira 1g vial

Dosage: _____

Start Date: _____

Patient's Weight: _____

BILLING INFORMATION

Place of administration:

 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 emphysema
- have a predicted FEV₁ value between 30 and 65%
- have a serum AAT level less than 60 mg/dL

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: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) must be recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only).

B. Does the patient have emphysema?

a. Yes

b. No – Rationale for use: _____

c. What is the patient's percent predicted FEV₁? _____

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

PRIORITY MEDICARE PLANS

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

PHYSICIAN STATEMENT

For Medicare only: If none of the above is applicable to this member, please check which, if any, of the following apply:

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX