

# Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to:  **Commercial (Traditional)**  **Commercial (Individual/Optimized)**

**Medicaid**

This request is:  **Urgent** (life threatening)  **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

## Aralast NP<sup>®</sup> (alpha<sub>1</sub>-proteinase inhibitor)

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Requesting Provider: \_\_\_\_\_ Prov. Phone: \_\_\_\_\_ Prov. Fax: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Product and Billing Information

New Request  Continuation Request

Drug product:  Aralast NP 0.5 gram vial

Aralast NP 1 gram vial

Start date (or date of next dose): \_\_\_\_\_

Date of last dose (if applicable): \_\_\_\_\_

Dosing frequency: \_\_\_\_\_

Place of administration:  Physician's office

Outpatient infusion

Facility: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

Home infusion

Facility: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

Billing:  Physician to buy and bill

Facility to buy and bill

Specialty Pharmacy

Pharmacy: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

ICD-10 Diagnosis code(s): \_\_\_\_\_

### Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of congenital alpha<sub>1</sub>-antitrypsin deficiency
2. Clinically evident emphysema
3. A predicted FEV<sub>1</sub> value between 30% and 65%
4. A serum alpha<sub>1</sub>-antitrypsin (AAT) level less than 11 mmol/L
  - 11 mmol/L is equal to 80 mg/dL if measured by radial immunodiffusion
  - 11 mmol/L is equal to 50 mg/dL if measured by nephelometry
5. Must be a non-smoker

**Note:** Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

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**Priority Health Precertification Documentation**

**A. What condition is this drug being requested for?**

- congenital alpha<sub>1</sub>-antitrypsin deficiency
- Other – the patient's condition is: \_\_\_\_\_  
Rationale for use: \_\_\_\_\_

**B. Does the patient have clinically evident emphysema?**

- Yes
- No – rationale for use: \_\_\_\_\_

**C. What is the patient's predicted FEV<sub>1</sub>?**

Date: \_\_\_\_\_ Value: \_\_\_\_\_ %

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

Date: \_\_\_\_\_ Provide one of the following values: \_\_\_\_\_ mmol/L  
\_\_\_\_\_ mg/dL (by radial immunodiffusion)  
\_\_\_\_\_ mg/dL (by nephelometry)

**E. Does the patient currently smoke?**

- No
- Yes – rationale for use: \_\_\_\_\_