PriorityHealth

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.

Prolastin® (alpha$_1$-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:

☐ Prolastin 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): _____

All fields must be complete and legible for review. Your office will receive a response via fax.

No changes made since 03/2011
Last reviewed 03/2019

Precertification Requirements

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

1. Diagnosis of congenital alpha$_1$-antitrypsin deficiency
2. Clinically evident emphysema
3. A predicted FEV_1 value between 30% and 65%
4. A serum alpha1-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.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ congenital alpha$_1$-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_1?

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: _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 03/2011
Last reviewed 03/2019