

## ALPHA-1 PROTEINASE INHIBITORS PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for Alpha-1 Proteinase Inhibitors, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Alpha-1 Proteinase Inhibitors (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request      # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient 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 Qty: _____ Refills: _____ Directions: _____	
<b>DIAGNOSIS:</b> _____ <b>DX CODE:</b> _____ <b>(REQUIRED)</b>	

#### All Requests

1. What is the Recipient'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 Recipient 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
<b>**Continue to INITIAL or RENEWAL section.**</b>	

#### Initial Requests

1. Does the Recipient 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 Recipient 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 Recipient have one of the following high-risk AATD genotypes? <u>Check the applicable genotype.</u> <input type="checkbox"/> Pi*ZZ <input type="checkbox"/> Pi*Z(null) <input type="checkbox"/> Pi*(null,null)	<input type="checkbox"/> Yes – <i>submit documentation of genotype testing method and results</i> <input type="checkbox"/> No

#### Renewal Requests

1. Have the Recipient'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 Recipient have results of recent spirometry testing since starting therapy?	<input type="checkbox"/> Yes – <i>submit documentation</i> <input type="checkbox"/> No
3. Has the Recipient experienced 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**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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