HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

ALPHA- 1 PROTEINASE INHIBITORS

Aralast NP®, Glassia®, Prolastin-C®, Zemaira®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Aralast NP® (alpha$_1$-proteinase inhibitor (human)), Glassia® (alpha$_1$-proteinase inhibitor (human)) ☐ Prolastin-C® (alpha$_1$-proteinase inhibitor (human)), ☐ Zemaira® (alpha$_1$-proteinase inhibitor (human))

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of alpha-1-antitrypsin (AAT) deficiency?	☐	☐	
2. Is the member 18 years of age or older?	☐	☐	
3. Does the member have a confirmed phenotype of PiZZ, piZ(null), or Pi(null)(null)?	☐	☐	**Please provide documentation**
4. Is the request made by, or in consultation with, a pulmonologist?	☐	☐	**Please provide documentation**
5. Does the member have clinically evident emphysema due to AAT deficiency?	☐	☐	**Please provide documentation**
6. Does documentation show a forced expiratory volume in one second (FEV1) between 30-65% OR a decline in FEV1 > 120 ml in 1 year?	☐	☐	
7. Does the member have a pretreatment serum concentration of AAT < 11µM/L (< 80mg/dL by radial immunodiffusion or 50mg/dL by nephelometry?	☐	☐	**Please provide documentation**
8. Is the member an active tobacco smoker?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show that the member has responded to treatment, such as elevated AAT levels above baseline and/or	☐	☐	**Please provide documentation**

substantial reduction in lung function deterioration as demonstrated by FEV1 values?			

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-002
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024