Alpha 1-Proteinase Inhibitors

(Aralast/Aralast NP, Prolastin/Prolastin-C, Zemaira, Glassia)

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-396-4139 FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:**	
Provider First Name:	**Provider Last Name:**	
Provider Phone:	**Provider Fax:**	**Provider NPI #:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**

Drug Requested:	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ New medication ❑ Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	❑Yes ❑No

Diagnosis:

Please indicate place of administration?	❑Physician Office ❑Hospital/Facility
Please provide facility/provider name and address:	

Please indicate how medication will be billed:

- ❑ Billed directly by the provider via JCODE
  Provide JCODE:_____
- ❑ Billed by a pharmacy and delivered to the provider
- ❑ Billed by a pharmacy and delivered to the patient

MEDICAL HISTORY

Does the member have a diagnosis congenital alpha 1-Antitrypsin deficiency?	☐ Yes ☐ No
Does the member have emphysema?	☐ Yes ☐ No
Does the member have airflow obstruction?	☐ Yes ☐ No
Does the member an alpha1-antitrypsin phenotype of PI*ZZ, PI*ZNull or PI*NullNull?	☐ Yes ☐ No

Please provide baseline serum alpha1-antitrypsin concentration:_____

How was the concentration determined? ☐ **Nephelometry** ☐ **Radial Immunodiffusion**

Is the member a smoker?	☐ Yes ☐ No
Does the member have selective IgA deficiencies with known antibodies against IgA (anti-IgA antibodies)	☐ Yes ☐ No

Please list all medications the member has previously tried or is currently using.

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

Please provide any additional information which should be considered in the space below: