

OPTIMA HEALTH COMMUNITY CARE AND OPTIMA FAMILY CARE (MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to **1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested - Alpha Proteinase Inhibitor (Select one from below):	
<input type="checkbox"/> ARALAST NP® (J0256)	<input type="checkbox"/> GLASSIA™ (J0257)
<input type="checkbox"/> PROLASTIN-C® (J0256)	<input type="checkbox"/> ZEMAIRA® (J0256)

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Name/Form: _____ Strength: _____
 Dosing Schedule: _____ Length of Therapy: _____
 Diagnosis: _____ ICD Code: _____
 Quantity per 30 days: _____

CLINICAL CRITERIA: Check **ALL** that apply. To qualify, applicable box(es) **MUST** be checked. Progress notes and labs **MUST** be submitted to verify each checked box. **Incomplete data will delay authorization process.**

- Diagnosis of congenital alpha-antitrypsin deficiency with emphysema YES NO
 Please specify the AAT phenotype deficiency below:
 PiZ PiZ (null) Pi (null, null) PiMZ PIMS
- Does the patient have clinical evidence of progressive panacinar emphysema? YES NO
- Does the patient's clinical record document a rate of decline in forced expiratory volume (FEV1) value between 30 and 65%? YES NO
- Serum AAT level must be: Date obtained: _____
 Specify result: mg/dL, uM/L, **OR** g/L **Date:** _____
- Serum AAT level **must** be: less than 11mmols/L
 less than 80mg/Dl if measured by radial immunodiffusion
 less than 50mg/Dl if measured by nephelometry
- Continuation of therapy from another plan, please fill out the above information along with labs and notes.

(continued on next page)

• **Continuation of therapy while insured with Optima:**

- Has the member been compliant on medication? YES NO
- Has the member demonstrated a clinical improvement in the past 3 months? YES NO

Serum AAT level **must** be: Date obtained: _____;
Specify result: mg/dL, uM/L, **OR** g/L; Date: _____

Medication being provided by (check applicable box below):

- Location/site of drug administration: _____
NPI or DEA # of administering location: _____
OR
- Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Number: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 8/1/2017; 5/25/2018; 8/15/2018;; 10/8/2018