OPTIMA HEALTH COMMUNITY CARE

(MEDICAID)

PHARMACY/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):	
❑ **ARALAST NP®** (J0256)	❑ **GLASSIA™** (J0257)
❑ **PROLASTIN-C®** (J0256)	❑ **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;~~ **(Reformatted) 2/4/2019**