

OPTIMA HEALTH COMMUNITY CARE

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 information below. If incomplete, 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: 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.
- 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 a Specialty Pharmacy:	<input type="checkbox"/> PropriumRx
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****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