

OPTIMA HEALTH PLAN

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 1-844-202-5034. 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 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 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: Briova SpecialtyRx

****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 #: _____

*Approved by Pharmacy and Therapeutics Committee: 2/11/2016

REVISED/UPDATED: 5/6/2016; 9/20/2016; 11/16/2016; 12/12/2016; 9/11/2017; 10/4/2017.