OPTIMA HEALTH PLAN

MEDICAL/PHARMACY PRIOR AUTHORIZATION 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**