FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
ALPHA$_1$-PROTEINASE INHIBITOR ENZYMES

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for Alpha$_1$-Proteinase Inhibitor enzymes. Payment for a non-preferred Alpha$_1$-Proteinase Inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment will be considered for patients when the following is met:

1. Patient has a diagnosis of congenital alpha$_1$-antitrypsin (AAT) deficiency; with a pretreatment serum concentration of AAT less than 11µM/L or 80mg/dl if measured by radial immunodiffusion, or 50mg/dl if measured by nephelometry; and
2. Patient has a high-risk AAT deficiency phenotype (PiZZ, PiZ (null), or PI (null)(null) or other phenotypes associated with serum AAT concentrations of less than 11µM/L, such as PiSZ or PiMZ); and
3. Patient has documented progressive panacinar emphysema with a documented rate of decline in forced expiratory volume in 1 second (FEV$_1$); and
4. Patient is 18 years of age or older; and
5. Patient is currently a non-smoker; and
6. Patient is currently on optimal supportive therapy for obstructive lung disease (inhaled bronchodilators, inhaled steroids); and
7. Medication will be administered in the member's home by home health or in a long-term care facility.

If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met:

1. Evidence of clinical efficacy, as documented by:
   a. An elevation of AAT levels (above protective threshold i.e., > 11µM/L); and
   b. A reduction in rate of deterioration of lung function as measured by a decrease in the FEV$_1$ rate of decline; and
2. Patient continues to be a non-smoker; and
3. Patient continues supportive therapy for obstructive lung disease.

Preferred: ☐ Prolastin C **Non-Preferred:** ☐ Aralast NP ☐ Glassia ☐ Zemaira

Strength_____ **Dosage instructions**_____ **Quantity**_____ **Days supply**_____

Diagnosis:_____

Provide member's AAT deficiency phenotype (attach results):_____

Pretreatment serum concentration of AAT (attach results):_____

Does member have progressive panacinar emphysema with documented rate of decline in FEV$_1$?

☐ Yes (attach documentation of FEV$_1$ decline) ☐ No

Is the member currently a smoker? ☐ Yes ☐ No

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Member is currently on supportive therapy for obstructive lung disease (inhaled bronchodilators, inhaled steroids):

☐ Yes (provide information below) ☐ No

Medication	Strength	Dosage Instructions	Start Date

Please indicate setting in which medication is to be administered:

☐ Home by home health ☐ Long-term care facility ☐ Other:_____

Renewal Requests:

List and attach updated AAT levels: Level:_____ Date:_____

Does member have of a reduction in rate of deterioration of lung function as measured by FEV$_1$:

☐ Yes (attach documentation) ☐ No

Does the member continue to be a non-smoker? ☐ Yes ☐ No

Is the member continuing supportive therapy for obstructive lung disease?

☐ Yes (provide information below) ☐ No

Medication	Strength	Dosage Instructions	Start Date

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*