



Please complete ALL information below and fax your request to 1-888-671-5285

Alpha-1 Proteinase Inhibitors Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic) <input type="checkbox"/> Check if request is for continuation of therapy	Strength:	Dosage Form:
Directions for Use:		

Clinical Information (required)
Select the Type of Coverage Determination Requested: <input type="checkbox"/> Prior Authorization- Request is for a drug that requires prior authorization under the plan.
Select the medication being requested below: <input type="checkbox"/> Aralast NP <input type="checkbox"/> Prolastin-C <input type="checkbox"/> Glassia <input type="checkbox"/> Zemaira
Select the diagnosis below: <input type="checkbox"/> Alpha-1 proteinase inhibitor deficiency [also known as alpha-1-antitrypsin (AAT) deficiency] <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Clinical Information: Does the patient have low serum concentration of alpha-1 antitrypsin, defined as less than 35% of normal (less than 80 mg/dL or less than 11 uM/L or less than 0.8 g/L)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have progressive panacinar emphysema with a documented rate of decline in forced expiratory volume in 1 second (FEV1)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have IgA deficiency with known anti-IgA antibody? <input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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