



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

Prolastin® C Prior Authorization Request Form

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

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Congenital alpha-1 antitrypsin (AAT) deficiency	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information:	
Does the patient have Pi*ZZ, Pi*Z(null), or Pi*(null)(null) protein phenotype (homozygous)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have other rare AAT disease-causing alleles associated with serum alpha1-antitrypsin (AAT) level less than 11 micromole per liter [e.g., Pi (Malton, Malton)]? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is circulating serum concentration of alpha1-antitrypsin (AAT) less than 11 micromole per liter (which corresponds to less than 80mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have a diagnosis of emphysema? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there continued optimal conventional treatment for emphysema (e.g., bronchodilators)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient's FEV1 level between 30% and 65% of predicted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120mL/year) that warrants treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient a current smoker? <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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