



MEDICARE FORM
Alpha 1 – Antitrypsin Inhibitor Therapy
Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review.)

Virginia (HMO D-SNP)
 FAX: 1-833-280-5224
 PHONE: 1-855-463-0933

For other lines of business:
 Please use other form.

Note: Aralast NP, Glassia and Zemaira are non-preferred. The preferred product is Prolastin-C.

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy: Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION			
First Name: _____		Last Name: _____	
Address: _____		City: _____	State: _____
Home Phone: _____		Work Phone: _____	Cell Phone: _____
DOB: _____	Allergies: _____		Email: _____
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms	
B. INSURANCE INFORMATION			
Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	
C. PRESCRIBER INFORMATION			
First Name: _____		Last Name: _____ (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address: _____		City: _____	State: _____
Phone: _____		Fax: _____	ZIP: _____
Provider Email: _____		St Lic #: _____	NPI #: _____
Office Contact Name: _____		DEA #: _____	
Specialty (Check one): <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Other: _____		UPIN: _____	
D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION			
Place of Administration:		Dispensing Provider/Pharmacy:	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home		<input type="checkbox"/> Outpatient Dialysis Center <input type="checkbox"/> Physician's Office	
<input type="checkbox"/> Outpatient Infusion Center Phone: _____		<input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy	
Center Name: _____		<input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Home Infusion Center Phone: _____		Name: _____	
Agency Name: _____		Address: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		City: _____ State: _____ ZIP: _____	
Address: _____		Phone: _____ Fax: _____	
City: _____ State: _____ ZIP: _____		TIN: _____ PIN: _____	
Phone: _____ Fax: _____		NPI: _____	
TIN: _____ PIN: _____			
NPI: _____			
E. PRODUCT INFORMATION			
Request is for: <input type="checkbox"/> Aralast NP <input type="checkbox"/> Glassia <input type="checkbox"/> Prolastin-C <input type="checkbox"/> Zemaira Dose: _____ Frequency: _____			
F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.			
Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____			
G. CLINICAL INFORMATION – Required clinical information must be completed in its <u>entirety</u> for all precertification requests.			
For All Requests: (clinical documentation required for all requests)			
Note: Aralast NP, Glassia and Zemaira are non-preferred. The preferred product is Prolastin-C.			
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior therapy with Aralast NP, Glassia, or Zemaira within the last 365 days?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a trial and failure, intolerance, or contraindication to Prolastin-C?			
Please explain if there are any other medical reason(s) that the patient cannot use Prolastin-C: _____ _____			

Continued on next page



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

- Yes No Is this infusion request in an outpatient hospital setting?
- Yes No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g. acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a immediately after an infusion?
- Yes No Does the patient have laboratory confirmed IgA antibodies?
- Yes No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
- Yes No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
 → Please provide a description of the behavioral issue or impairment: _____
- Yes No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
 → Please provide a description of the condition: Cardiovascular: _____
 Respiratory: _____
 Renal: _____
 Other: _____
- Yes No Has the patient been diagnosed with alpha 1-antitrypsin (AAT) deficiency?
- Yes No Does the patient have a documented diagnosis of emphysema due to alpha 1-antitrypsin (AAT) deficiency?

For Initiation of Therapy:

- Yes No Is this request for Aralast NP, Glassia, or Zemaira?
 → Yes No Has the patient had an intolerance or an ineffective response to Prolastin-C?
 → Yes No Does the patient have a contraindication to Prolastin-C?
- Yes No Is the patient's pretreatment post-bronchodilation FEV1 (forced expiratory volume 1 second) greater than or equal to 25 percent and less than or equal to 80 percent of the predicted value?
 Please provide the patient's pretreatment alpha 1-antitrypsin (AAT) serum concentration: _____ specify result: mg/dL, uM/L, g/L, or µmol/L
 Please specify the alpha 1-antitrypsin (AAT) protein phenotype: PiZZ PiZ (null) Pi (null, null) PiMZ PiMS
 Other phenotype associated with serum AAT concentrations of less than 11 micromol/L (80mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry)
 Unknown

For Continuation of Therapy:

- Yes No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
- Yes No Is the patient experiencing beneficial clinical response from therapy?

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.