

Alpha 1-Proteinase Inhibitors
(Aralast/Aralast NP, Prolastin/Prolastin-C, Zemaira, Glassia)

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-396-4139

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY
Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No
Diagnosis:			
Please indicate place of administration?	<input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/Facility	Please indicate how medication will be billed:	
Please provide facility/provider name and address:		<input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____	
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	

MEDICAL HISTORY

Does the member have a diagnosis congenital alpha 1-Antitrypsin deficiency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member have emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member have airflow obstruction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member an alpha1-antitrypsin phenotype of PI*ZZ, PI*ZNull or PI*NullNull?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide baseline serum alpha1-antitrypsin concentration: _____	
How was the concentration determined?	<input type="checkbox"/> Nephelometry <input type="checkbox"/> Radial Immunodiffusion
Is the member a smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member have selective IgA deficiencies with known antibodies against IgA (anti-IgA antibodies)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list all medications the member has previously tried or is currently using.

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

Please provide any additional information which should be considered in the space below:
