AAT Deficiency

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____kg

Patient Height: _____*cm*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____ *Route of administration* _____

Dosing frequency _____

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home based setting, *skip to Criteria Questions*
- ❑ Community office, *skip to Criteria Questions*
- ❑ Ambulatory infusion site, *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or

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seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. 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? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. 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? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. What drug is being prescribed? ❑ Aralast NP ❑ Glassia ❑ Prolastin-C ❑ Zemaira ❑ Other _____
2. What is the diagnosis?
   ❑ Alpha$_1$-antitrypsin (AAT) deficiency (also known as alpha$_1$-proteinase inhibitor deficiency)
   ❑ Other (please specify) _____
3. What is the ICD-10 code? _____
4. Does the patient have emphysema due to alpha1-antitrypsin (AAT) deficiency? ❑ Yes ❑ No
5. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #8*
6. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown skip to #8*
7. Is the patient experiencing beneficial clinical response from therapy? ❑ Yes ❑ No *No further questions*
8. Is the patient's pretreatment post-bronchodilation FEV_1 (forced expiratory volume in 1 second) greater than or equal to 25 percent and less than or equal to 80 percent of the predicted value? ***ACTION REQUIRED: If Yes, attach supporting test results.*** ❑ Yes ❑ No
9. What is the patient's pretreatment serum alpha$_1$-antitrypsin (AAT) level? ***ACTION REQUIRED: If Yes, attach supporting test results.*** _____micromol/L OR mg/dL ***(circle units)*** ❑ No serum AAT level
10. Has testing been done to establish the patient's alpha$_1$-antitrypsin protein phenotype or genotype? ***ACTION REQUIRED: If Yes, attach alpha1-antitrypsin phenotyping test result.*** ❑ Yes ❑ No
11. What is the patient's alpha$_1$-antitrypsin protein phenotype?

❑ PiZZ ❑ PiZ (null) ❑ Pi (null, null) ❑ PiMZ ❑ PiMS
❑ Other phenotype or genotype associated with serum AAT concentrations of less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry)
❑ Unknown

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

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