Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Alpha-1 Proteinase Inhibitors

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for reauthorization? If YES, go to 2. If NO, go to 5.

☐ Yes ☐ No

Q2. Is the request for reauthorization for a patient diagnosed with emphysema? If YES, go to 3. If NO, go to 4.

☐ Yes ☐ No

Q3. Is serum alpha1-antitrypsin (AAT) concentration attached to show levels above protective threshold of 11 micromol/L (or 57 mg/dL using nephelometry or 80 mg/dL by radial immunodiffusion).

☐ Yes ☐ No

Q4. Are chart notes attached documenting clinical benefit with requested alpha-1 proteinase inhibitor?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Does the member have a documented diagnosis with chart notes of emphysema due to severe congenital deficiency of Alpha-1-proteinase inhibitor (Alpha1-PI)? If YES, go to 6. If NO, go to 8.

☐ Yes ☐ No

Q6. Are lab results provided documenting baseline (pretreatment) serum alpha1-antitrypsin concentration of less than 11 micromol/L (57mg/dL as determined by nephelometry OR less than 80mg/dL by radial immunodiffusion)? If YES, go to 7.

☐ Yes ☐ No

Q7. Is documentation of testing provided identifying the specific genotype responsible for AATD: Pi*ZZ, Pi*Z(null) or Pi*(null)(null) or other phenotype associated with a serum AAT concentration of less than 11 micromol/L.

☐ Yes ☐ No

Q8. Are chart notes attached documenting the diagnosis?

☐ Yes ☐ No

Q9. Does the member have Immunoglobulin A (IgA) deficiency with known antibodies to IgA?

☐ Yes ☐ No

Q10. Is the medication prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

Q11. Is the requested drug formulary Prolastin-C?

☐ Yes ☐ No

Q12. Is documentation attached of inadequate response, intolerance, or contraindication to formulary agents indicated for patient's diagnosis that would not be expected to occur with requested agent ?

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☐ Yes	☐ No
Q13. Additional Information:	

Prescriber Signature _____ Date _____

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