MEDICARE FORM
Alpha 1 – Antitrypsin Inhibitor Therapy Medication Precertification Request

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

For Illinois MMP:
FAX: 1-855-320-8445
PHONE: 1-866-600-2139

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:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Pulmonologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ Aralast NP ☐ Glassia ☐ Prolastin-C ☐ 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 entirety 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.

☐ Yes ☐ No Has the patient had prior therapy with Aralast NP, Glassia, or Zemaira within the last 365 days?
☐ Yes ☐ 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

aetna®

MEDICARE FORM
Alpha 1 – Antitrypsin Inhibitor Therapy Medication Precertification Request

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

For Illinois MMP:
FAX: 1-855-320-8445
PHONE: 1-866-600-2139

For other lines of business:
Please use other form.

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

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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.