



## **Aralast® (alpha-proteinase inhibitor)**

### PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

1. Date:	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: \_\_\_\_\_ to \_\_\_\_\_  
 Not to exceed 1 year for initial therapy. Additional therapy may be approved for up to 2 years.

Question	Yes	No	Comments/Notes
12. Is the prescribing provider a pulmonologist?			
13. Is the diagnosis documented as congenital deficiency of alpha-1 proteinase inhibitor?			
14. If 'yes' to 13, has the diagnosis been confirmed by the determination of the alpha-1 antitrypsin concentration in blood of < 100 mg/dL and the gene product of the patient?			
15. Does the patient have clinically evident emphysema?			
16. Does the patient have antibodies to IgA?			
17. Is the patient 18 years of age or older?			
18. Has the patient had an adequate trial and failure to Prolastin®?			
19. Has the patient had previous treatment with Aralast®?			
20. If 'yes' to 19, did the patient experience an increase in serum alpha-1 proteinase inhibitor levels?			Documentation is required.
21. Source of Medication (please select one): <input type="checkbox"/> Accredo <input type="checkbox"/> Approved Home Health			If no selection is made, Accredo must be used.
22. Indicate the facility Aralast® is to be administered:			
23. Physician's Signature: _____			

### PEHP USE ONLY

Site of approval: Accredo or Approved Home Health

Home Health J-code: J0256

#### Confidentiality Notice

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