# 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): ☐ Accredo ☐ 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** | |
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| **Site of approval**: Accredo or Approved Home Health | **Home Health J-code**: J0256 |