Alpha 1 – Antitrypsin Inhibitor Therapy Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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
☐ Outpatient Infusion Center Phone: ______________
Center Name: ______________
☐ Home Infusion Center Phone: ______________
Agency Name: ______________
☐ Administration code(s) (CPT): ______________
Address: ______________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: ______________
Name: ______________
Address: ______________
Phone: ______________ Fax: ______________
TIN: ______________ PIN: ______________

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)

☐ Yes ☐ No Does the patient have a documented diagnosis of emphysema due to alpha 1-antitrypsin (AAT) deficiency?
☐ Yes ☐ No Is there documentation of a low serum concentration of alpha 1-antitrypsin (AAT)?
Please provide the patient's alpha 1-antitrypsin (AAT) serum concentration _____ specify result: mg/dL, uM/L, g/L, or µmol/L
Please indicate how the alpha 1-antitrypsin (AAT) was measured: ☐ Nephelometry ☐ Radial immunodiffusion
Please specify the alpha 1-antitrypsin (AAT) phenotype deficiency: Please select: ☐ PiZZ ☐ PiZ (null) ☐ Pi (null, null) ☐ PiMZ ☐ PiMS
☐ Yes ☐ No Does the patient have other phenotypes associated with serum alpha 1-antitrypsin (AAT) concentrations of less than 80 mg/dL?
☐ Yes ☐ No Does the patient have clinical evidence of progressive panacinar emphysema?
☐ Yes ☐ No Does the patient's clinical record document a rate of decline in forced expiratory volume in 1 second (FEV1)?
☐ Yes ☐ No Does the patient smoke?
☐ Yes ☐ No Is there clinical evidence that the patient is immunoglobulin (IgA) antibody deficient with antibodies to immunoglobulin (IgA)?

For Continuation of Therapy:

☐ Yes ☐ No Is there clinical documentation indicating that there is disease stability or improvement?
Please select: ☐ Disease stability ☐ Improvement

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.