



**MEDICARE FORM**  
**Alpha 1 – Antitrypsin Inhibitor Therapy**  
**Medication Precertification Request**

Page 1 of 2

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

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

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 #: _____  |                  | Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                                       |
| Group #: _____  |                  | If yes, provide ID#: _____ Carrier Name: _____  |                                       |
| Insured: _____  |                  | Insured: _____  |                                       |
| Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____  |                  | Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____  |                                       |
| C. PRESCRIBER INFORMATION   |                  |   |                                       |
| First Name: _____   |                  | Last Name: _____ (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A. |                                       |
| Address: _____  |                  | City: _____   | State: _____ ZIP: _____               |
| Phone: _____  | Fax: _____       | St Lic #: _____   | NPI #: _____ DEA #: _____ UPIN: _____ |
| Provider Email: _____   |                  | Office Contact Name: _____ Phone: _____   |                                       |
| Specialty (Check one): <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Other: _____   |                  |   |                                       |
| D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION   |                  |   |                                       |
| <b>Place of Administration:</b>   |                  | <b>Dispensing Provider/Pharmacy:</b>  |                                       |
| <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home  |                  | <input type="checkbox"/> Outpatient Dialysis Center <input type="checkbox"/> Physician's Office   |                                       |
| <input type="checkbox"/> Outpatient Infusion Center Phone: _____  |                  | <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy  |                                       |
| Center Name: _____  |                  | <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____   |                                       |
| <input type="checkbox"/> Home Infusion Center Phone: _____  |                  | Name: _____   |                                       |
| Agency Name: _____  |                  | Address: _____  |                                       |
| <input type="checkbox"/> Administration code(s) (CPT): _____  |                  | City: _____ State: _____ ZIP: _____   |                                       |
| Address: _____  |                  | Phone: _____ Fax: _____   |                                       |
| City: _____ State: _____ ZIP: _____   |                  | <b>TIN:</b> _____ <b>PIN:</b> _____   |                                       |
| Phone: _____ Fax: _____   |                  | NPI: _____  |                                       |
| <b>TIN:</b> _____ <b>PIN:</b> _____   |                  |   |                                       |
| NPI: _____  |                  |   |                                       |
| E. PRODUCT INFORMATION  |                  |   |                                       |
| Request is for: <input type="checkbox"/> Aralast NP <input type="checkbox"/> Glassia <input type="checkbox"/> Prolastin-C <input type="checkbox"/> 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.  |                  |   |                                       |
| <b>For All Requests: (clinical documentation required for all requests)</b>   |                  |   |                                       |
| <b>Note: Aralast NP, Glassia and Zemaira are non-preferred. The preferred product is Prolastin-C.</b>   |                  |   |                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior therapy with Aralast NP, Glassia, or Zemaira within the last 365 days?                               |                  |   |                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a trial, intolerance, or contraindication to Prolastin-C?  |                  |   |                                       |
| Please explain if there are any other medical reason(s) that the patient cannot use Prolastin-C:<br>_____<br>_____  |                  |   |                                       |

Continued on next page



**MEDICARE FORM**  
**Alpha 1 – Antitrypsin Inhibitor Therapy**  
**Medication Precertification Request**

Page 2 of 2

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

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

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.