AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Alpha Proteinase Inhibitor

Drug Requested: (Select ONE drug below)

❑ **ARALAST NP® (J0256)**	❑ **GLASSIA® (J0257)**
❑ **PROLASTIN-C® (J0256)**	❑ **ZEMAIRA® (J0256)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Requested per 30 days: _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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Quantity Limit (max daily dose) [NDC/HCPCS Unit]:

- Aralast NP: 1000 mg (1 vial) = 100 billable units; NDC: 00944-2815-01
- Aralast NP: 500 mg (1 vial) = 50 billable units; NDC: 00944-2814-01
- Glassia: 1,000 mg/50 mL (1 vial) = 100 billable units; NDC: 00944-2884-XX
- Prolastin-C: 1,000 mg/20 mL (1 vial) = 100 billable units; NDC: 13533-0705-XX
- Prolastin-C: 1,000 mg (1 vial) = 100 billable units; NDC: 13533-0700-02; 13533-0703-10
- Zemaira: 1,000 mg (1 vial) = 100 billable units; NDC: 00053-7201-02

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ❑ Member has a diagnosis of congenital alpha-antitrypsin deficiency with emphysema
- ❑ Provider must specify the member's AAT phenotype deficiency:

❑ PiZ	❑ PiZ (null)	❑ Pi (null, null)	❑ PiMZ	❑ PIMS

- ❑ Member has clinical evidence of progressive panacinar emphysema
- ❑ Member is a current non smoker
- ❑ Member's clinical record documents a rate of decline in forced expiratory volume (FEV_1) value between 30 and 65% **(submit pulmonary function test results)**
- ❑ Serum AAT level must be submitted (**specify result & date obtained**): _____ mg/dL, µmol /L

  Date: _____/_____/_____
- ❑ Serum AAT level must meet **ONE** of the following:
- ❑ < 11 µmol/L
  - ❑ < 80 mg/dL if measured by radial immunodiffusion
  - ❑ < 57 mg/dL if measured by nephelometry

Continuation of therapy: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ For continuation of therapy from another plan, please fill out the information in the initial authorization section above and submit along with required labs and chart notes

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- ❑ For continuation of therapy while insured with AvMed, **ALL** the following must be met:
  - ❑ Member has been compliant with medication
  - ❑ Member has demonstrated a clinical improvement in the past 3 months
  - ❑ Serum AAT level must be submitted (**specify result & date obtained**): _____ mg/dL, µmol /L
    Date: _____/_____/_____

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.