pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ALPHA-1 PROTEINASE INHIBITORS PRIOR AUTHORIZATION FORM *(Form effective 7/1/2022)*

Prior authorization guidelines for **Alpha-1 Proteinase Inhibitors** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # of pages: ______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	☐Aralast NP ☐Glassia** *(specialty drug – see below)*	☐Prolastin-C ☐Zemaira
Directions:		
Beneficiary weight: _________ lbs / kg	Quantity per fill: __________________ vials / milligrams	Refills:
Diagnosis:	Dx code (required):	

**SPECIALTY PHARMACY DRUG PROGRAM: Glassia is included in the DHS Specialty Pharmacy Drug Program and is available from DHS's specialty pharmacy. Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Specialty-Pharmacy-Program.aspx for more information about the Specialty Pharmacy Drug Program.	**DHS specialty pharmacy:** Chartwell Pennsylvania, LP Oakdale, PA Phone: 833-710-0211 Fax: 412-920-1869 www.chartwellpa.com
What is the beneficiary's smoking status? Check one. ☐non-smoker ☐former smoker ☐current smoker	*Submit supporting chart documentation*
Is the beneficiary IgA deficient with antibodies against IgA?	☐Yes – *Submit documentation.* ☐No
If prescriber is NOT a pulmonologist, is the requested medication being prescribed in consultation with a pulmonologist?	☐Yes – *Submit documentation of consultation.* ☐No or not applicable

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INITIAL Requests	
Does the beneficiary have documentation of a baseline (pre-treatment) alpha-1 antitrypsin serum level?	☐Yes – *Submit documentation of testing method and results.* ☐No
Does the beneficiary have clinically evident emphysema secondary to severe alpha-1 antitrypsin deficiency (AATD)?	☐Yes – *Submit documentation of results of spirometry and other diagnostic tests.* ☐No
Does the beneficiary have one of the following high-risk AATD phenotypes? Check the applicable phenotype. ☐Pi*ZZ ☐Pi*Z(null) ☐Pi*(null,null) ☐Pi*SZ	☐Yes – *Submit documentation of laboratory analysis and results.* ☐No
RENEWAL Requests	
Have the beneficiary's signs and symptoms of emphysema associated with AATD improved or stabilized since starting therapy?	☐Yes – *Submit documentation.* ☐No
Does the beneficiary have results of recent spirometry testing since starting therapy?	☐Yes – *Submit documentation.* ☐No
Did the beneficiary experience a decrease in frequency, duration, or severity of pulmonary exacerbations of emphysema?	☐Yes – *Submit documentation.* ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:

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