OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Aralast NP®, Glassia®, Prolastin-C® & Zemaira® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: / Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the diagnosis below:

❑ Alpha-1 antitrypsin (ATT) deficiency

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have congenital ATT deficiency? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of emphysema? ❑ **Yes** ❑ **No**

Was the diagnosis of emphysema confirmed with pulmonary function testing? ❑ **Yes** ❑ **No**

Does the patient continue to receive optimal treatment for emphysema (e.g., bronchodilators)? ❑ **Yes** ❑ **No**

Select if the patient has the following high risk phenotypes or alleles:

- ❑ Pi*ZZ protein phenotype (homozygous)
- ❑ Pi*Z(null) protein phenotype (homozygous)
- ❑ Pi*(null)(null) protein phenotype (homozygous)
- ❑ Other rare ATT disease-causing alleles associated with serum alpha-1 antitrypsin (ATT) level less than 11 micromole per liter [e.g., Pi(Malton, Malton)]

Does the patient have a circulating serum concentration of alpha-1 antitrypsin (ATT) level <11 micromole per liter (which corresponds to < 80 mg/dL if measured by radial immunodiffusion or < 57 mg/dL if measured by nephelometry)? ❑ **Yes** ❑ **No**

Does the patient have a FEV1 between 30% and 65% of predicted? ❑ **Yes** ❑ **No**

Has the patient experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment? ❑ **Yes** ❑ **No**

For Aralast NP, Glassia and Zemaira requests: Has the patient had a trial and failure, or intolerance to Prolastin-C? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **No**

Does the patient continue to receive optimal treatment for emphysema (e.g., bronchodilators)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.