AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Alpha1-proteinase inhibitor enzymes

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for Alpha1-Proteinase Inhibitor enzymes. Payment for a non-preferred Alpha1-Proteinase Inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment will be considered for patients when the following is met:

1. Patient has a diagnosis of congenital alpha1-antitrypsin (AAT) deficiency; with a pretreatment serum concentration of AAT less than 11µM/L or 80mg/dl if measured by radial immunodiffusion, or 50mg/dl if measured by nephelometry; and
2. Patient has a high-risk AAT deficiency phenotype (PiZZ, PiZ (null), or PI (null)(null) or other phenotypes associated with serum AAT concentrations of less than 11µM/L, such as PiSZ or PiMZ); and
3. Patient has documented progressive panacinar emphysema with a documented rate of decline in forced expiratory volume in 1 second (FEV_1); and
4. Patient is 18 years of age or older; and
5. Patient is currently a non-smoker; and
6. Patient is currently on optimal supportive therapy for obstructive lung disease (inhaled bronchodilators, inhaled steroids); and
7. Medication will be administered in the member's home by home health or in a long-term care facility.

If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met:

1. Evidence of clinical efficacy, as documented by:
   a. An elevation of AAT levels (above protective threshold i.e., > 11µM/L); and
   b. A reduction in rate of deterioration of lung function as measured by a decrease in the FEV_1 rate of decline; and
2. Patient continues to be a non-smoker; and
3. Patient continues supportive therapy for obstructive lung disease.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred: ☐ Prolastin C Non-Preferred: ☐ Aralast NP ☐ Glassia ☐ Zemaira

Strength: Dosage instructions: Quantity: Days supply:

Diagnosis:

Provide member's AAT deficiency phenotype (attach results):

Pretreatment serum concentration of AAT (attach results):

Does member have progressive panacinar emphysema with documented rate of decline in FEV_1?
☐ Yes (attach documentation of FEV_1 decline) ☐ No

Is the member currently a smoker? ☐ Yes ☐ No

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Member is currently on supportive therapy for obstructive lung disease (inhaled bronchodilators, inhaled steroids):
☐ Yes (provide information below) ☐ No

Medication	Strength	Dosage Instructions	Start Date

Please indicate setting in which medication is to be administered:
☐ Home by home health ☐ Long-term care facility ☐ Other:

Renewal Requests: List and attach updated AAT levels: Level: Date:

Does member have of a reduction in rate of deterioration of lung function as measured by FEV_1:
☐ Yes (attach documentation) ☐ No

Does the member continue to be a non-smoker? ☐ Yes ☐ No

Is the member continuing supportive therapy for obstructive lung disease? ☐ Yes (provide information below) ☐ No

Medication	Strength	Dosage Instructions	Start Date

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.