UnitedHealthcare Community Plan

Respiratory Agents – MISC: Alpha-Proteinase Inhibitor (Human) - Washington

Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Is this for the FDA approved indication for augmentation and maintenance therapy of a patient with severe hereditary deficiency of alpha1-antitrypsin (AAT) with clinical evidence of emphysema?**
□ Yes □ No	**Is the diagnosis confirmed by genetic confirmation of PiZZ, PiZ(null), or Pi(null, null) phenotype alpha1-antitrypsin deficiency (AATD) or other alleles determined to increase risk of AATD?**
□ Yes □ No	**Is the diagnosis confirmed by one of the following lab values testing for AAT?** *(If yes, check which applies and list levels)* □ Test levels of AAT: less than 11 µmol/L, *List level:* □ Immunoturbidimetry: less than or equal to 57 mg/dL, *List level:* □ Nephelometry: less than or equal to 57 mg/dL □ Radial immunodiffusion: less than or equal to 80 mg/dL, *List level:*
□ Yes □ No	**Is the diagnosis confirmed by documented emphysema with airflow obstruction?**
□ Yes □ No	**Did the prescriber document that the member's forced expiratory volume in one second (FEV1) is less than or equal to 65% predicted?** *List FEV1:*
□ Yes □ No	**Did the prescriber verify that the patient is a non-smoker or is initiating smoking cessation?**
□ Yes □ No	**Did the prescriber verify the patient does not have antibodies to IgA?**
□ Yes □ No	**Was the diagnosis established by, or in consultation with, a specialist in pulmonology?**
□ Yes □ No	**Is the patient's recent weight provided in order to authorize the appropriate amount of drug required according to package labeling?** *List weight and date:*
CONTINUATION OF THERAPY	
□ Yes □ No	**Is there documentation of a positive clinical response from pretreatment baseline to alpha1-proteinase inhibitor treatment?** *If yes, list positive response:*

Provider Signature: _____ Date: _____