AAT Deficiency

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: ______________________________ **Date**: __________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** __________________
Physician's Name: ____________________________ **NPI#:** _________________________________
Specialty: __________________________________ **HPHC Provider ID**______________________
Physician Office Telephone: __________________ **Physician Office Fax:** _____________________

<u>Rendering</u> Provider Info: ❑ Same as Requesting Provider **HPHC Provider ID:**______________________
Name: ____ **NPI#:** ______________________________
Fax: _____________________ **Phone:** __________________ **Provider Tax ID:** _______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Additional Demographic Information:</u>

Please indicate the place of service for the requested drug:
❑ Ambulatory Surgical ❑ Home ❑ Inpatient Hospital ❑ Off Campus Outpatient Hospital
❑ On Campus Outpatient Hospital ❑ Office ❑ Pharmacy

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

1. What drug is being prescribed?
   ❑ Aralast NP ❑ Glassia ❑ Prolastin-C ❑ Zemaira
2. What is the diagnosis and ICD-10 code?
   ❑ $Alpha_1$-antitrypsin (AAT) deficiency ❑ Other ______________________________________

   ICD-10 code: _______________
3. Does the patient have emphysema due to AAT deficiency?
   <u>If yes, please attach supporting documentation (i.e., medical records).</u> ❑ Yes ❑ No
4. Does the member have one of the high-risk phenotypes (PI*ZZ, PI*Z [null], or, PI* [null][null])?
   <u>If yes, please attach supporting documentation (i.e., medical records).</u> ❑ Yes ❑ No
5. Prior to initiation of therapy, does the member have airflow obstruction as evidenced by forced expiratory volume (FEV1) of 30-65% of predicted value?
   <u>If yes, please attach supporting documentation (i.e., medical records) and skip to #7</u> ❑ Yes ❑ No

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. AAT HPHC – 4/2018.

6. Did the member experience rapid decline in lung function as measured by a change in FEV1 greater than 120 ml/year? ***If yes, please attach supporting documentation (i.e., medical records***) ❑ Yes ❑ No
7. What is the patient's pretreatment serum AAT level?
   ACTION REQUIRED: Attach test results. **____________ µM/L OR mg/dL** ***(circle units)***
   ❑ No serum AAT level
8. What is the member's current smoking status? ***Please attach supporting documentation (i.e., medical records).***
   ❑ Smoker ❑ Non-smoker
9. Is this request for initiation or continuation of therapy?
   If initial therapy, no further questions ❑ Initiation ❑ Continuation
10. Is the member receiving benefit from therapy (i.e., normalized or improved plasma AAT levels as compared to baseline) ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. AAT HPHC – 4/2018.