BlueCross BlueShield Federal Employee Program.

ALPHA$_1$-PROTEINASE INHIBITORS PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

For Standard and Basic Option patients Prolastin-C is a preferred product. Please consider prescribing the preferred product. Standard/Basic Option patients who switch to the preferred product will be eligible for 2 copays at no cost in the benefit year.

Alpha$_1$-Proteinase Inhibitors

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑**Aralast NP** ❑**Glassia** ❑**Zemaira**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. **Standard/Basic Option:** Would you like to participate in this program and switch the patient to Prolastin-C? ❑Yes ❑No*
   If NO,** does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Prolastin-C? ***Please select answer below:
   ❑**Yes** ***(specify result)***: _____
   ❑**No**: Is there a clinical reason for not trying Prolastin-C? ❑Yes* ❑No
   ***If YES**, please specify: _____
2. Does the patient have a diagnosis of emphysema? ❑Yes ❑No
3. Is the patient currently a smoker? ❑Yes ❑No
4. Has the patient been on this medication continuously for the last **2 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Is there documentation of alpha$_1$ antitrypsin (AAT) deficiency? ❑Yes* ❑No
   If YES**, was the deficiency determined by radial immunodiffusion, nephelometry, or serum AAT level? ***Answer below:
   ❑**Immunodiffusion**: What is the patient's level in milligrams per deciliter? _____ mg/dL
   ❑**Nephelometry**: What is the patient's level in milligrams per deciliter? _____ mg/dL
   ❑**Serum ATT level**: What is the patient's serum AAT level in micrometers per liter? _____ uM/L
   ❑**Other** ***(please specify)***: _____

b. Does the patient have documentation of progressive emphysema with moderate airflow obstruction evidenced by forced expiratory volume (FEV_1) of 30 to 65% of predicted value? ❑Yes ❑No

c. Does the patient have documentation of progressive emphysema and has had a rapid decline in lung function as measured by a change in FEV_1 greater than 120 milliliters per year? ❑Yes ❑No

d. Does the patient have documentation of progressive emphysema with a forced expiratory volume (FEV_1) greater than 65% predicted? ❑Yes* ❑No
   ***If YES**, does the patient have bronchiectasis with one or more severe exacerbations resulting in an emergency department (ED) visit or hospitalization within the last year? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has there been an elevation of the patient's AAT levels above the protective threshold? ❑Yes ❑No*
   ***If NO**, has there been a reduction in the rate of deterioration of lung function as shown by a reduction in FEV_1 rate of decline? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***