



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Alpha-1 Proteinase Inhibitors - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Member Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.  
Please answer the following questions and sign.**

<p>Q1. Is the member 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Does the member have a diagnosis of emphysema due to severe congenital deficiency of Alpha1-P1?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Has the drug been prescribed by or in consultation with a pulmonologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Does the member have Immunoglobulin A (IgA) deficiency with known antibodies to IgA?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Has, included with the request, documentation of testing that confirms one of the following homozygous protein phenotypes: Pi*ZZ, Pi*Z(null) or Pi*(null)(null) AND labs that show baseline (pretreatment) serum alpha1-antitrypsin concentration of less than 11 micromol/L as documented by either of the following: less than 57mg/dL as determined by nephelometry OR less than 80mg/dL as determined by radial immunodiffusion)?</p>

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Alpha-1 Proteinase Inhibitors - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Member Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Additional Information:	
Q7. Requested Duration:	
<input type="checkbox"/> 12 months	<input type="checkbox"/> Other

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2025