Prescriber Criteria Form
Alpha-1 Proteinase Inhibitors 2025 PA Fax 11-A v1 010125.docx
Aralast NP, Glassia, Prolastin-C, Zemaira (alpha1-proteinase inhibitor [human])
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Alpha-1 Proteinase Inhibitors.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of alpha1-proteinase inhibitor deficiency (also known as alpha1-antitrypsin deficiency)? [If no, then no further questions.]	Yes ◯	No ◯
2	Does the patient have clinically evident emphysema? [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a pretreatment serum alpha1-proteinase inhibitor level less than 11 micromoles per liter (80 milligrams per deciliter by radial immunodiffusion or 50 milligrams per deciliter by nephelometry)?	Yes ◯	No ◯

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____