UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

PROLASTIN, ZEMAIRA (alpha-1-proteinase inhibitor)

Patient name:________________________________Medicaid ID #:_________________________________

Prescriber Name:________________Prescriber NPI#:_____________ Contact person:_________________

Prescriber Phone#:___________________Extension/Option:____________ Fax#:____________________

Pharmacy:___________________Pharmacy Phone#:_______________Pharmacy Fax #:_______________

Requested Medication:___________________________Strength:__________Frequency/Day:___________

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992 note the new fax number

CRITERIA:

- **DOCUMENTED** Alpha-1 Antitrypsin deficiency **AND**
- **DOCUMENTED** Panacinar Emphysema
- Must have stopped smoking for at least 30 days, as documented by physician.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Updated letter of medical necessity

9/20/10

http://health.utah.gov/medicaid/pharmacy