

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ARALAST (alpha-1-proteinase inhibitor)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and opt. _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

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

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

- ▶ Diagnosis of Emphysema
- ▶ Current treatment
- ▶ Treatment failures
- ▶ Explanation of condition that demands augmentation with Aralast

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

1 year with documentation of sustained improvement