

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

PROLASTIN, ZEMAIRA (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:

- ▶ **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:

Telephone request from physician's office or pharmacy.