

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ARALAST (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

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992**

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

9/13/10

<https://medicaid.utah.gov/pharmacy/>