

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**

**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

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