

**AAT Deficiency  
Prior Authorization Request**

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

**Additional Demographic Information:**

*Patient Weight:* \_\_\_\_\_ kg  
*Patient Height:* \_\_\_\_\_ ft \_\_\_\_\_ inches

**Criteria Questions:**

1. What drug is being prescribed?  
 Aralast NP  Glassia  Prolastin-C  Zemaira  Other \_\_\_\_\_
2. What is the diagnosis?  
 Alpha<sub>1</sub>-antitrypsin (AAT) deficiency  Other \_\_\_\_\_
3. What is the ICD-10 code? \_\_\_\_\_
4. Does the patient have clinically evident emphysema?  Yes  No
5. What is the patient's pretreatment post-bronchodilation FEV<sub>1</sub> percentage of the predicted value?  
 \_\_\_\_\_ % predicted  No FEV<sub>1</sub> results
6. What is the patient's pretreatment serum AAT level?  
 \_\_\_\_\_ micromol/L OR mg/dL (*circle units*)  No serum AAT level

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X** \_\_\_\_\_  
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

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