reliance|rx℠
45 Earhart Drive, Suite 110, Amherst, NY 14221

PURIFIED PROTEINASE INHIBITORS AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name First Name	Today's Date Date Needed
Parent/Guardian	Prescriber Hospital/Clinic
Home Phone Number ( ) Work Phone Number ( )	Phone Number ( ) Fax Number ( )
Home Address City State Zip	Address City State Zip
Ship To: ☐ Prescriber ☐ Patient's Home	Office Contact Prescriber Speciality
Language Preference ☐ English ☐ Spanish ☐ Other	
Known Allergies:	Contact Preference ☐ Phone ☐ Fax ☐ Email: _____
Weight _____ Lbs. Height ____ Ft ____ In Date of Birth ___ / ___ / ___ Sex ☐ M ☐ F	Special Instructions

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: _____
Name of Insured: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____

Secondary Insurance: _____
Name of Insured: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD9 Code: _____

Patient has congenital deficiency of alpha 1 proteinase with clinically evident emphysema as documented by:

☐ Submission of full pulmonary function tests including:
- ☐ Spirometry showing obstruction AND
- ☐ Lung volume with evidence of high residual volumes and high total lung capacity AND
- ☐ Diffusion capacity
- ☐ Chest x-ray or CT scan of the chest showing hyperinflated lungs

The authorization request must come from a pulmonologist (or under the documented recommendation of a pulmonologist) AND

Prolastin® is Independent Health's preferred product for all new patient starts. Authorization of Aralast® or Zemaira® is only provided in cases where the prescribing physician documents that the patient has tried and failed to respond to or tolerate therapy with Prolastin®.

PURIFIED PROTEINASE INHIBITORS

☐ New Authorization ☐ Re-authorization*

Dose: _____

Frequency: _____