ALPHA1 THERAPY REFERRAL FORM

Phone (888) 370.1724 Fax (855) 370.0086

AMBER™ SPECIALTY PHARMACY

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies	Latex Allergy ☐ Yes ☐ No	
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax	Email	

Diagnosis and Clinical Information

Diagnosis (ICD-10):

E88.01 (Congenital Emphysema) Alpha1-Antitrypsin Deficiency Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____

FEV1: _____% predicted

Serum A1AT levels (pretreatment) _____ md/dl or _____ microM

Does the patient display clinically evident emphysema? Yes No

Needs by Date: _____ **Ship to** **Patient** **Office** **Other:** _____

Lab Orders: _____

Nursing: **Please arrange nursing administration** **Patient may be taught to self-infuse**

Prescription Information

Medication	Dose and Directions		Quantity	Refills
Aralast®	60mg/kg via IV infusion once every week other _____ _____ mg/kg via IV infusion once every week other _____		4 week supply 12 week supply	1 year _____
Glassia®	60mg/kg via IV infusion once every week other _____ _____ mg/kg via IV infusion once every week other _____		4 week supply 12 week supply	1 year _____
Zemaira®	60mg/kg via IV infusion once every week other _____ _____ mg/kg via IV infusion once every week other _____		4 week supply 12 week supply	1 year _____
Epinephrine® IM SQ	Adult 1:1000, 0.3mL (>30kg/>66lbs) Peds 1:2000, 0.3mL (15-30kg/33-66lbs)	PRN Anaphylaxis Repeating Dose: _____	Once _____	1 year _____
Normal Saline D5W	3mL 5mL Other _____	IV before and after infusion _____	1 month 3 months _____	1 year _____
Heparin 10 units/mL Heparin 100 units/mL	3mL 5mL Other _____	IV before and after infusion _____	1 month 3 months _____	1 year _____
Other:_____				
Vascular Access Method:	peripheral central other: _____			

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)