

# ALPHA<sub>1</sub> THERAPY REFERRAL FORM

Phone (888) 370.1724 Fax (855) 370.0086



Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name			
Address						Address			
City		State		ZIP		City		State	ZIP
Phone			SSN			Prescriber Name			
Allergies						Latex Allergy Yes No			
Sex Male Female		Weight (kg)		Height (ft,in)		Prescriber NPI		Nurse/Key Contact	Phone/Pager
Insurance Plan			Plan ID #			Fax		Email	

Diagnosis and Clinical Information	
<b>Diagnosis (ICD-10):</b> E88.01 (Congenital Emphysema) Alpha1-Antitrypsin Deficiency      Other Code: _____ Description: _____	
<b>Patient Clinical Information:</b>	
Allergies: _____ <b>Needs by Date:</b> _____ <b>Ship to</b> <b>Patient</b> <b>Office</b> <b>Other:</b> _____	
FEV1: _____ % predicted <b>Lab Orders:</b> _____	
Serum A1AT levels (pretreatment) _____ md/dl or _____ microM <b>Nursing: Please arrange nursing administration      Patient may be taught to self-infuse</b>	
Does the patient display clinically evident emphysema?      Yes      No	

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 _____
Normal Saline D5W	3mL 5mL Other _____	IV before and after infusion _____	1 month 3 months _____
Heparin 10 units/mL Heparin 100 units/mL	3mL 5mL Other _____	IV before and after infusion _____	1 month 3 months _____
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)

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