Alpha-1 proteinase inhibitor therapy referral form

FAX: 800-987-6552
Phone: 877-283-8679

PATIENT INFORMATION ☐ See attached

Patient Name:	Gender: ☐ Male ☐ Female	DOB:	
Address:	City:	State:	Zip:
Phone:	Cell:		
Emergency Contact:	Phone:	Relationship:	

INSURANCE INFORMATION

Please provide copy of card

PRIMARY DIAGNOSIS

☐ E88.01-Alpha-1 antitrypsin ☐ Other:

MEDICAL ASSESSMENT Attach supportive clinical documents including patient's current pulmonary status

Height (in):	Weight (kg):	Date weight obtained:
Received Alpha-1 Protease replacement therapy before? ☐ Yes ☐ No	Prior brand name received/include copy of all current medications:	
Allergies:	Serum AAT Level & Date:	FEV1 % Predicted & Date:
Smoking status: ☐ Curent ☐ Past ☐ Never	Phenotype/Genotype:	

PRESCRIPTION & ORDERS Medication infused per the drug PI recommended rate and via rate controlled device per therapy

Medication	Dose and Directions
Aralast® NP	First Dose: ☐ Yes ☐ No If NO, indicate when next dose is needed: _____ ☐ Infuse Aralast NP 60 mg/kg or _____ mg (+/-15%) intravenously once weekly via a rate controlled device. ☐ Infuse Aralast NP _____ mg (+/-15%) intravenously once every _____ weeks via a rate controlled device. Infuse over approximately 15 minutes at a rate not to exceed 0.2 mL/kg/min as tolerated by the patient. Dispense Aralast NP in quantity sufficient for 4 weeks supply or _____ Refill 1x year unless otherwise noted for _____ times or PRN for 1 year
Glassia®	First Dose: ☐ Yes ☐ No If NO, indicate when next dose is needed: _____ ☐ Infuse Glassia 60 mg/kg or _____ mg (+/-15%) intravenously once weekly via a rate controlled device. ☐ Infuse Glassia _____ mg (+/-15%) intravenously once every _____ weeks via a rate controlled device. Infuse over approximately 15 minutes at a rate not to exceed 0.2 mL/kg/min as tolerated by the patient. Dispense Glassia in quantity sufficient for 4 weeks supply or _____ Refill 1x year unless otherwise noted for _____ times or PRN for 1 year
Prolastin-C Liquid®	First Dose: ☐ Yes ☐ No If NO, indicate when next dose is needed: _____ ☐ Infuse Prolastin-C Liquid 60 mg/kg or _____ mg (+/-15%) intravenously once weekly via a rate controlled device. ☐ Infuse Prolastin-C Liquid _____ mg (+/-15%) intravenously once every _____ weeks via a rate controlled device. Infuse over approximately 15 minutes at a rate not to exceed 0.08 mL/kg/min as tolerated by the patient. Dispense Prolastin-C Liquid in quantity sufficient for 4 weeks supply or _____ Refill 1x year unless otherwise noted for _____ times or PRN for 1 year
Zemaira®	First Dose: ☐ Yes ☐ No If NO, indicate when next dose is needed: _____ ☐ Infuse Zemaira 60 mg/kg or _____ mg (+/-15%) intravenously once weekly via a rate controlled device. ☐ Infuse Zemaira _____ mg (+/-15%) intravenously once every _____ weeks via a rate controlled device. Infuse over approximately 15 minutes at a rate not to exceed 0.08 mL/kg/min as tolerated by the patient. Dispense Zemaira in quantity sufficient for 4 weeks supply or _____ Refill 1x year unless otherwise noted for _____ times or PRN for 1 year

Ancillary orders

Lab Orders, x1 year	Specify lab(s) for nurse to draw: _____ Frequency: _____ Lab work to be obtained via IV access using aseptic technique. If RN is not able to draw labs via central catheter, RN may draw labs peripherally. RN to flush IV access after each blood draw with Sodium Chloride 0.9% 20 mL. As final lock for patency, use Heparin 10units/mL, 5mL, or if Port use Heparin 100units/mL, 5mL.
Nursing Orders, x1 year	RN to insert peripheral IV or access central catheter. RN to administer prescribed medication. RN to flush IV with Sodium Chloride 0.9%, 5mL pre-infusion and 5mL post infusion. If port access, flush with Sodium Chloride 0.9% 10mL pre-infusion and 10mL post-infusion. As a final lock for patency RN to use heparin 10 unit/mL, 3mL or if port, lock with heparin 100 units/mL, 5mL. RN to assess and instruct patient/caregiver in all aspects of medication administration, IV access device, disease process, and signs and symptoms of complications..
Pharmacy Orders, x1 year	Pharmacy to dispense flushes, needles, syringes and HME/DME quantity sufficient to complete therapy as prescribed
☐ Anaphylaxis mgmt, x1 year (Select check box to order)	Stop infusion and remove infusion set needle from body to prevent further administration of causative drug. Administer contents of EPINEPHrine auto injector (pen) as an IM injection into the lateral thigh. Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist. Administer CPR if needed until EMS arrive. Notify prescribing physician after EMS care is received and condition is stable. Pharmacy to dispense weight appropriate EPINEPHrine autoinjector #2 as follows. For patient weight >30kg, EPINEPHrine dose 0.3mg/0.3mL For patient weight 15-30kg, EPINEPHrine dose 0.15mg/0.15mL

PHYSICIAN INFORMATION

Name:	Practice:		
Address:	City:	State:	Zip:
Phone:	Fax:	NPI:	Contact:

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

_____ Substitution permissible signature

_____ Dispense as written signature

_____ Date

Please fax: ☐ Completed form
☐ Demographic sheet/insurance information
☐ Clinical notes and labs, as applicable