# Alpha-1 Proteinase Inhibitor Deficiency
## REFERRAL FORM

**FAX REFERRAL TO:** +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

## 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

**Patient Name:** _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
**Address:** _____ **City/State/Zip:** _____
**Primary Phone:** _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
**Emergency Contact:** _____ **Relationship to Patient:** _____ **Phone:** _____

## 2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

**Primary Insurance:** _____ **Policy No:** _____ **Group:** _____
**Primary RX Insurance:**_____ **ID No:**_____ **RX GRP:**_____ **RX BIN:**_____ **RX PCN:**_____

## 3 DIAGNOSIS AND CLINICAL INFORMATION

**First time receiving Alpha 1 therapy?** ☐ Yes ☐ No **If No, previous product used:** _____ **Last Dose Given:** _____

**Patient Clinical Information:**

**Diagnosis** (ICD-10): ☐ E88.01 (Congenital Emphysema) Alpha1-Antitrypsin Deficiency ☐ Other: _____ Description: _____
**Drug Allergies:**_____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg **Do you want dose adjusted for weight > 100 kg?** ☐ NO ☐ YES
**Phenotype:** ☐ ZZ ☐ SZ ☐ MZ ☐ MS ☐ SS ☐ Other: _____ **Smoking History:** ☐ Current ☐ Former ☐ None
**Serum A1AT levels** (pretreatment) _____ mg/dL or _____ microM **FEV1:** _____ % predicted
**Does the patient display clinically evident emphysema?** ☐ Yes ☐ No

**Labs:** Please fax copy of the following labs dated within 1 year of the patients referral request: ☐ **CMP** ☐ **CBC w/diff** ☐ **Lung Imaging** ☐ **Hep(B) Vaccine Series** ☐ **QuantiFERON (QFT) / TB** ☐ **PFT** ☐ **Serum AAT with genotype**

## 4 PRESCRIPTION INFORMATION

**ACCESS:** ☐ IV ☐ Implanted PORT ☐ Other: _____

**RX INFORMATION:** Our pharmacist will identify clinically calculate appropriate dosing based off of Acceptable allotment +/- 10% based on vial lot/batch per FDA guidelines. Official orders will be outlined with "May Infuse" +/- 3 days if scheduling needs arises, with insurance payor approval".

**PRODUCT:** ☐ Zemaira ☐ Other: _____

**DOSE:** 60 mg/kg X _____ Kg (pt weight)= Total Dose _____ mg once every week for 1 Year, unless specified.

**DOSE:** Other _____mg/kg x _____kg (pt weight) = Total Dose _____mg every _____ week for 1 Year, unless specified.

**PRE/POST ORDERS:**

| MEDICATION | DIRECTION | QUANTITY | REFILLS |
|---|---|---|---|
| ☐ Diphenhydramine: ☐ PO ☐ IV | Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN. | Quantity: **Q.S** | Refills: **PRN** |
| ☐ Acetaminophen **(PO)** | Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN. | Quantity: **Q.S** | Refills: **PRN** |
| ☐ SoluMedrol® | Give _____ mg prior to infusion via ☐ IV push ☐ diluted in _____ mL of NS over 30 minutes. | Quantity: **Q.S** | Refills: **PRN** |
| ☐ Emla® cream | Apply topically 30 to 60 minutes prior to access. | Quantity: **Q.S** | Refills: **PRN** |

**ANAPHYLAXIS PROTOCOL:**

| MEDICATION | DIRECTION | QUANTITY | REFILLS |
|---|---|---|---|
| ☒ EPINEPHRINE **(vial or autoinjector)** | Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)*** | Quantity: **(x1) Vial** or **(x2) Pen(s)** | Refills: **PRN** |
| ☒ DIPHENHYDRAMINE **(50mg/mL )** | Administer via IM or slow IV push for severe anaphylactic reaction. ☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)*** | Quantity: **(x1) Vial** | Refills: **PRN** |
| ☒ SODIUM CHLORIDE 0.9% **(IV)** | Infuse 500 mL IV as directed for severe anaphylactic reaction. | Quantity: **Q.S** | Refills: **PRN** |

**NURSING/ LABS/ INFUSION SUPPLIES:**

☒ **NURSING:** Nursing visits with each infusion to establish venous access, administer medication, provide education, and assess / monitor patient. *** May adjust infusion schedule +/- 3 days if need arises ***** Up to 4 skilled nursing visits—to train patient / caregiver on medication administration, assess / monitor patient, and provide education—for the purposes of working towards independent administration of nurse. PRN visits thereafter to refresh skills.

☒ **INFUSION SUPPLIES:** Infusion supplies and infusion pump PRN for the administration and disposal of medication.

**FLUSHING PROTOCOL:** ☒ Sodium chloride 0.9%, up to 10 mL before/after medication, and/or PRN to maintain patency.
☐ Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency

## 5 PRESCRIBER INFORMATION

**Prescriber Name:** _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:**_____
**Address:**_____ **City/ State/ Zip:** _____
**Phone:**_____ **Fax:** _____ **Contact Person:**_____

**The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.**
I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.
**CONFIDENTIALITY NOTICE:** The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to **info@ivsolutionsrx.com** and destroy all copies of the original message.

**Physicians signature** **Date**

**THANK YOU FOR YOU TRUSTING US IN YOUR PATIENTS SPECIALTY CARE** *#welcome to our family*


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