

Alpha-1 Proteinase Inhibitor Deficiency REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049

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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
<input type="checkbox"/> Diphenhydramine: <input type="checkbox"/> PO <input type="checkbox"/> IV	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Acetaminophen (PO)	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> SoluMedrol®	Give _____ mg prior to infusion via <input type="checkbox"/> IV push <input type="checkbox"/> diluted in _____ mL of NS over 30 minutes.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Emla® cream	Apply topically 30 to 60 minutes prior to access.	Quantity: Q.S	Refills: PRN

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input checked="" type="checkbox"/> EPINEPHRINE (vial or autoinjector)	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes <input type="checkbox"/> 0.3 mg (Wt > 30 kg) <input type="checkbox"/> 0.15 mg (Wt 15-30 kg) <input type="checkbox"/> 0.1 mg (Wt 7.5-15 kg)	Quantity: (x1) Vial OR (x2) Pen(s)	Refills: PRN
<input checked="" type="checkbox"/> DIPHENHYDRAMINE (50mg/mL)	Administer via IM or slow IV push for severe anaphylactic reaction. <input type="checkbox"/> 50 mg (Wt > 30 kg) <input type="checkbox"/> 25 mg (Wt 15-30 kg) <input type="checkbox"/> 12.5mg (Wt 7.5-15kg)	Quantity: (x1) Vial	Refills: PRN
<input checked="" type="checkbox"/> 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 SIGNATURE REQUIRED **(STAMP SIGNATURE NOT ALLOWED)**

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

DISPENSE AS WRITTEN BRAND MEDICALLY NECESSARY DO NOT SUBSTITUTE May Substitute / Product Selection Permitted / Substitution Permissible
 NO SUBSTITUTION / DAW / MAY NOT SUBSTITUTE

Prescriber's Signature: _____ Date: _____ Prescriber's Signature: _____ Date: _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

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.

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THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE

#welcome to our family