ALPHA1 THERAPY REFERRAL FORM

Phone (877)794.9833 Fax (855)370.0086
215 10th Street, Suite 110 Des Moines, IA 50309

Pharmacy
Hy-Vee SOLUTIONS

Patient 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		Prescriber NPI		
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)	Nurse/Key Contact	Phone/Pager	
Insurance Plan	Plan ID #		Fax	Email	

Diagnosis and Clinical Information

Diagnosis (ICD-10):

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

Patient Clinical Information:

Height: _____in/cm Weight: _____lb/kg **Needs by Date:** _____ **Ship to** **Patient** **Office** **Other:** _____

Allergies: _____ **Lab Orders:** _____

FEV1: _____% predicted **Nursing:** **Please arrange nursing administration** **Patient may be taught to self-infuse**

Serum A1AT levels (pretreatment) _____md/dl or _____microM

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 _____	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: _____

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PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) **DISPENSE AS WRITTEN/Do Not Substitute (date)**