

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

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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 DSW	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: \_\_\_\_\_

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:

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

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