ALPHA1 THERAPY REFERRAL FORM

Phone (888) 370.1724 Fax (855) 370.0086

Amber PHARMACY

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies	Latex Allergy ☐ Yes ☐ No	
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax	Email	

Diagnosis and Clinical Information

Diagnosis (ICD-10):

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

Patient Clinical Information:

Allergies:_____

FEV1:_____% predicted

Serum A1AT levels (pretreatment)_____md/dl or_____microM

Does the patient display clinically evident emphysema? Yes No

Needs by Date:_____ **Ship to Patient Office Other:** _____

Lab Orders: _____

Nursing: Please arrange nursing administration Patient may be taught to self-infuse

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:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)