ALPHA1 THERAPY REFERRAL FORM

Phone (844) 703.3645 Fax (855) 370.0086
10 Medical Parkway, Suite 107 Farmers Branch, TX 75234

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:

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:

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)

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Amber Enterprises, Inc., dba Amber Pharmacy © 2018