# Alpha-1 Referral Form

**Fax completed form to: 833-908-1122**

amerita specialty infusion services

InfusionRx an amerita company

## PATIENT INFORMATION

| | | |
|---|---|---|
| Patient Name: | Date of Birth: | Referral Date: |
| Address: | City/State/Zip: | |
| Home Phone: | Cell Phone: | Work Phone: |
| Secondary Contact: | Height: Weight: | ☐ Male ☐ Female |
| Patient Diagnosis & ICD-10: | | |
| Allergies: | | |

## PROVIDER INFORMATION

| | | |
|---|---|---|
| Physician Name: | Lic.#: | DEA #: |
| Practice Name: | | NPI#: |
| Address: | | City/State/Zip: |
| Office Contact: | Phone: | Fax: |
| Supervisory Physician (if applicable): | | |

## MS CLINICAL DETAILS

**Type of MS:** ☐Primary progressive multiple sclerosis (PPMS) ***---OR---*** ☐Relapsing multiple sclerosis (RMS)
**Ambulation status:** ☐Able to ambulate more than 5 meters ☐Able to ambulate without aid or rest for at least 100 meters
**Relapse details:** ☐Two or more relapses within the previous two years ☐One relapse within the previous year

## PLEASE ATTACH

☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
☐ Recent office visit notes, history & physical, lab & pertinent procedure results
☐ Current medication list & list of prior medications tried and failed (with dates)
☐ Alpha-1 antitrypsin levels, FEV1 score, & smoking status
☐ Line access documentation/verification if applicable
☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

## NURSING & LAB ORDERS

**Nurse Orders:** Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.
**Flush Orders:** *NaCl 0.9%* - 5-10mL flush pre and post infusion and as needed *Heparin* - ☐ 10units/mL ***---OR---*** ☐100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line
**Lab Orders:** **Lab Date & Frequency:**

## PRESCRIPTION ORDERS

**Anaphylaxis Kit:** (Check all that apply)
☐ Epinephrine 0.3mg IM as needed
☐ Diphenhydramine _____ mg IV infusion as needed
☐ Solu-cortef 250mg-500mg IV infusion as needed
☐ NS Hydration 500 ml IV infusion over 30 minutes as needed
☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Other

**Pre-Medications:** (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion
☐ Diphenhydramine _____ mg as needed
☐ Solu-Medrol _____mg IV infusion _____minutes prior to infusion
☐ PO ***---OR---*** ☐ IV infusion _____minutes prior to infusion
☐ Other

**Supply Orders:** All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

| PRODUCT | PRESCRIPTION INFORMATION | REFILLS |
|---|---|---|
| Is this a first dose? ☐ Yes ☐ No If No, when was last dose given?_____ When is patient due for next dose?_____ | | |
| ☐ ARALAST | 60mg/kg IV infusion via ☐gravity ***---OR---*** ☐pump weekly over approximately 15 minutes<br>**Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch* | |
| ☐ GLASSIA | 60mg/kg IV infusion via ☐gravity ***---OR---*** ☐pump weekly over approximately 15 minutes<br>**Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch* | |
| ☐ OTHER | | NONE _____ |

***By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.***

**Prescriber's Signature** **Print Name** **Date**
**Dispense as Written**

**Prescriber's Signature** **Print Name** **Date**
**Substitution Permitted**


*AME IRX_ALPHA1 REFER 10-23*



ACHC ACCREDITED PCAB ACCREDITED Compounding Pharmacy