Alpha-1 Referral Form

Fax Completed Form To: **Phone:**

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)	☐ Alpha-1 antitrypsin levels, FEV1 score, & smoking status
☐ Recent office visit notes, history & physical, lab & pertinent procedure results	☐ Line access documentation/verification if applicable
☐ Current medication list & list of prior medications tried and failed (with dates)	☐ 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:	☐ Epinephrine 0.3mg IM as needed	☐ Solu-cortef 250mg-500mg IV infusion as needed	☐ Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply)	☐ Diphenhydramine ________ mg IV infusion as needed	☐ NS Hydration 500 ml IV infusion over 30 minutes as needed	☐ Other
Pre-Medications:	☐ Acetaminophen ________mg PO ________ minutes prior to infusion	☐ Solu-Medrol ______mg IV infusion ______minutes prior to infusion	
(Check all that apply)	☐ Diphenhydramine ________ mg as needed	☐ 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 **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 **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 **<u>Dispense as Written</u>**	**Print Name**	**Date**	**Prescriber's Signature** **<u>Substitution Permitted</u>**	**Print Name**	**Date**

urac ACCREDITED Specialty Pharmacy
ACHC ACCREDITED
PCAB ACCREDITED Compounding Pharmacy

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