Alpha-1 Referral Form

Fax Completed Form To: **Phone:**

amerita
specialty infusion services

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
☐ Solu-cortef 250mg-500mg IV infusion as needed
☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____ mg IV infusion as needed
☐ NS Hydration 500 ml IV infusion over 30 minutes as needed
☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion
☐ Solu-Medrol _____mg IV infusion _____minutes prior to infusion
☐ 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

Is this a first dose? ☐ Yes ☐ No If No, when was last dose given?_____ When is patient due for next dose?_____

PRODUCT	PRESCRIPTION INFORMATION	REFILLS
☐ 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 **Print Name** **Date**
Dispense as Written

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

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