## Alpha-1 Referral Form

## **Fax Completed Form To:**







PATIENT INFORMATION						
Patient Name:		Date of Birth:		Referi	ral Date:	
Address:				City/State/Zip:		
Home Phone:		Cell Phone:		Work	Phone:	
Secondary Contact:		Height:	Weight:	M	ale 🗆 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) ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines						25
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/mLOR 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders:  Lab Date & Frequency:						
PRESCRIPTION ORDERS						
Anaphylaxis Kit:						
	□ Acetaminophenmg PO □ Diphenhydraminemg as need	•		mg IV infusion IV infusionminu	•	□ Other
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary						
PRODUCT		PRESCRII	PTION INFORMATI	ON		REFILLS
Is this a first 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 <b>OR</b> ☐ 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 Dispense as Written	Print Name	Date	Prescriber's Signa Substitution Peri		Print Name	Date





