## Alpha-1 Referral Form





Fax Completed Form To:

**Phone:** 

Patent Name:         Date of Brith:         Orgy/State/Zp:           Home Phone:         City/State/Zp:         Work Phone:           Secondary Contact:         Height:         Work Phone:         Secondary Contact:         Male         Female           Patent Diguosis & LO-10:         Male         Female         Female <th colspan="8">PATIENT INFORMATION</th>	PATIENT INFORMATION							
Hene Phone: Coll Phone:   Secondary Contact: Height:   Weik Phone: Male   Secondary Contact: Height:   Weik Phone: Male   Allergies: PROVIDER INFORMATION   Physion Name: LLc.#.   Debte: DBte   Practice Name: LLC.#.   Practice Name: ClayState/Zip:   Address: ClayState/Zip:   Office Contact: Phone:   Secondary Contact: Phone: </td <td>Patient Name:</td> <td colspan="2"></td> <td></td> <td>F</td> <td colspan="2">Referral Date:</td>	Patient Name:				F	Referral Date:		
Secondary Contact:       Height:       Weight:       Male       Female         Patter Disposits & (CD-10:       Allergies:       PROVIDER INFORMATION       PROVIDER INFORMATION         Physician Name:       LCut:       DEA I:       Procession (CD-10:)         Physician Name:       LCut:       DEA I:       Procession (CD-10:)         Procession (CD-10:)       NPIE:       OnlyState/Zip:       OnlyState/Zip:         Office Contact:       Phone:       Fac:       Secondary Contact:       Secondary Contact:       NPIE:         Supervisory Physician (If applicable):       MS CLINICAL DETAILS       Secondary Contact:	Address:	City/State/Zip:						
Predict Dagoods & ICD-10:         Allergies:         Product Name:         Protice Name:         Diskin Name:         Protice Name:         Office Grant:         Supervisory Physician (If applicable):         Mice Status:         Office Grant:         Prote Name:         Multiple of MS:         Primary progressive multiple sclerosis (PMS)         Andress:         Office Grant:         Point or more relapses within the previous two yeas:         One relapse details:         Iwo or more relapses within the previous two yeas:         One relapse details:         Iwo or more relapses within the previous two yeas:         One relapse details:         Iwo or more relapses within the previous two yeas:         P LEASE ATTACH         P Lease Sci Sci Michael Copy of All Insurance cards (precription Related)         Iwas Orders: Nation test, history & physical, lab & perfinent procedure result:         Use String & Lease Sci Sci Michael Copy of All Insurance cards (precription Relation and vascual access device intertion and/or management per physical and related (with dates)         Use Drokers: Nation Dest:       NURSING & LAB ORDERS         Nurse Orders: Nation Dest:       PRESCRIPTION ORDERS         Anaphylaxis Kit:       Epinephylore and as need	Home Phone:			V	Work Phone:			
Allergies:       PROVIDER INFORMATION         Physician Name:       Lic.#:       DEA.#:         Practice Name:       NPU:         Address:       Office Contact:       Phone:         Supervisory Physician (if applicable):       Fac:         Supervisory Physician (if applicable):       Supervisory Physician (if applicable):         Supervisory Physician (if applicable):       MS CLINICAL DETAILS         Type of MS:       Phinary progressive multiple sclerosis (PMS) — OR	Secondary Contact:	Height: Weight:				🗆 Male 🛛 Female		
PROVIDER INFORMATION           Physician Name:         U.c.#         D6A #:           Physician Name:         U.c.#         D6A #:           Address:         City/Sate/Zip:         City/Sate/Zip:           Office Contact:         Phone:         Fac           Supervisory Physician (if applicable):         More:         Fac <b>NSC CLINICAL DETAILS Supervisory Physician</b> (if applicable): <b>NECONTACL DETAILS Supervisory Physician</b> (if applicable): <b>NECONTACL DETAILS Supervisory Physician</b> (if applicable): <b>PLEASE ATTACH</b> Patient demographics & front/back copy of all insurance cards (prescription & medical)            apha-1 antitrypsin breeks, FKV1 score, & smoking status              Current medications list & list of prior medications tried and failed (with dates)            Letter of medical necessity if drug dosing or indication is outside of FDA guidelines <b>NURS Orders:</b> Nucl 20%: 5' Tom flush pre and post infusion and an eceld. <b>NURS Orders:</b> Nucl 20%: 5' Tom flush pre and post infusion and a needed. <b>Orders:</b> Nucl 20%: 5' Tom flush pre and post infusion and an eceld. <b>Order Strug Provide assessment, teaching, lab draws, medication administration and vascular </b>	Patient Diagnosis & ICD-10:							
Physican Name:       Lic.#:       D6.4:         Pradice Name:       NPIR:         Pradice Name:       NPIR:         Address:       OffySate/Zip:         Office Gratad:       Phone:         Supervisory Physican (If applicable):       Fax:         Type of MS:       Phimary progressive multiple sclenosis (PMS) — OR								
Practice Name:       NPIE:         Address:       Cfty/State/Zfg:         Office Contact:       Phone:         Supervisory Physican (if applicable):       Fax:         Supervisory Physican (if applicable):       MS CLINICAL DETAILS         Type of MS:       Phinary progressive multiple sclerosis (PMS)OR lealapsing multiple sclerosis (RMS)         Ambulation status:       Able to ambulate more than 5 meters:       habe to ambulate mither the previous two years         Patient demographics & front/back copy of all insurance cards (prescription & medical)          Alpha-1 antityppin levels, FEV1 score, & smoking status            Patient demographics & front/back copy of all insurance cards (prescription & medical)          Alpha-1 antityppin levels, FEV1 score, & smoking status            Current medication is this of prior medications stried and failed (with dates)          Liter of medical mescily infrug dosing or indication is outside of FDA guidelines         Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vasualar access device insection and/or management per physician orders.       I Lab Date & Trequency:         PRESCRIPTION ORDERS         Anaphylaxis Kit:          Diphenhydraminem gp Ominuteprior to infusion	PROVIDER INFORMATION							
Address:       City/State/Zip:         Office Contact:       Phone:       Fax         Supervisory Physician (if applicable):       MS CLINICAL DETAILS         Type of MS:       Primary progressive multiple sclerosis (PMS) OR	Physician Name:	Lic.#: DEA #:						
Office Contact:       Phone:       Fax:         Supervisory Physician (if applicable):       MS CLINICAL DETAILS         Type of MS:       Primary progressive multiple sclerosis (RMS)         Ambulation status:       Able to ambulate more than 5 meters:       Able to ambulate more than 5 meters:         Able to ambulate more than 5 meters:       Able to ambulate more than 5 meters:       Able to ambulate more than 5 meters:         Place Setatils:       Two more relapses within the previous wy ear       PLEASE ATTACH         Place Acting with notes, history & physical, lab & pertiment procedure results       Dete arcses documentation/venfication if applicable         Current medication list & list of prior medications tried and failed (with dates)       Letter of medical necessity if drug dosing or indicable         Nurse Orders:       NURSING & LAB ORDERS         Nurse Orders:       Nurse Orders: Nard0 9% - 5-10mL flush pre and post infusion and as needed       Heganin - 100mit/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line         Lab Orders:       Narke Orders:       Narke Post-infusion NS flush if indicated to maintain line         Lab Orders:       Narke Orders:       Narke Post-infusion and as needed       Isou-order 250mg-900mg VI infusion as needed       Other         Prestedications:       A Reataminophen       mg PO       minutes prior to infusion       Other         Supply Orders:	Practice Name:			NPI#:				
Supervisory Physician (if applicable):         MS CLINICAL DETAILS         Type of MS:    Phimary progressive multiple sclerosis (PMS)	Address:				City/State/Zip:			
MS CLINICAL DETAILS         Type of MS:       Primary progressive multiple sclerosis (PMS)       Ambulation status:       Albe to ambulate more than S meters:       Albe to ambulate without alo or rest for at least 100 meters         Relapse details:       Two or more relapses within the previous two years       PLEASE ATTACH         Platient demographics & front/back copy of all insurance cards (prescription & medical)       Deha - 1 antitrypsin levels, FVI score, & smoking status         Current medication list & list of prior medications tried and failed (with dates)       Line access documentation/verification if applicable         Letter of medical necessity if drug dosing or indication is outside of FDA guidelines         Nurse Orders:       Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.         Flush 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:       Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.         Flush Orders:       Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration on an seeded       Solu-ortef 250mg-500mg IV infusion as needed       Others: Nacl 0.9% - 125mg IV infusion as needed       Solu-ortef 250mg-500mg IV infusion as needed       Other					Fax:			
Type of MS:       Primary progressive multiple sclerosis (PMS)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 years       PLEASE ATTACH         Platent demographics & front/back copy of all insurance cards (prescription & medical)       Apha-1 antitrysin levels, FEV1 score, & smoking status         Current medication list & list of prior medications tried and falled (with dates)       Eleter of medical necessity if drug dosing or indication is outside of FDA guidelines         Nurse Orders:       Nurse 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:       Nurse Orders:       Lab Date & Frequency:         PRESCRIPTION ORDERS       Anaphylaxis Kit:       Epinephrine 0.3mg IM as needed       Solu-Cref 250mg-500mg IV infusion as needed       Other         Supply Orders:       Index attraphyly       Diphenhydramine       mg as needed       INS Hydration Solu Wetord       Other         Supply Orders:       Index attraphyly       Diphenhydramine       mg as needed       INS Hydration Sol IV infusion       Infusion       Other         Supply Orders:       Index attres of thydration Nis (Indix on thy as needed       INS H								
Ambulation status:       Able to ambulate more than 5 meters       Able to ambulate without ald or rest for at least 100 meters         Relayed details:       Two or more relapses within the previous year         Platient demographics & front/back copy of all insurance cards (prescription & medical)       Alpha-1 antitypsin levels, FEV1 score, & smoking status         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         Nurse Orders:       NURS ING & LAB ORDERS         Nurse Orders:       Lab Date & Frequency:         Lab Orders:       Lab Date & Frequency:         Prescention and/or management per physician orders.       Fluish Orders: Nord 0.9% - 5 Tom. flush pre and post infusion and vascular access device insertion and/or management per physician orders.         Rusphylaxis Kit:       E plipterhine 0.3mg M as needed       Heparin - 1 Ounits/mL 0R 1 100units/mL - 3 fmL flush after post-infusion NS flush if indicated to maintain line Lab Orders:         Lock kall that apply)       Diphenhydramine       mg V infusion as needed       Oslu Meter J 200mg V/m flusion as needed       Oslu Meter J 200mg V/m Flusion       Demoters         Veck kall that apply)       Diphenhydramine       mg V infusion as needed       NO H POOR -       Winfusion       Demoters         Veck kall that apply)       Diphenhydramine (mg as needed)       NS Hydration 500 ml W infusion o	MS CLINICAL DETAILS							
Patient demographics & font/back copy of all insurance cards (prescription & medical) Alpha-1 antitrypsin levels, FEV1 score, & smoking status   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 and wascular access device insertion and/or management per physician orders.   Fush Orders: Na/00.9% - 510mL flush pre and post infusion and as needed <i>Heprini</i> - 10 Units/mL0P+ 1000mits/mL -3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Date & Frequency:   Names Orders: Nurse to provide assessment, teaching lab draws, medication and wascular access device insertion and/or management per physican orders.   Pre-Medications: Acteaminophenmg P0minutes prior to infusion as needed   Other   Pre-Medications: Acteaminophenmg P0minutes prior to infusionminutes prior to infusionmg P00R+-   IV infusionminutes 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 fus a first dose? YesNo if No, when was last dose giver?When is patient due for next dose?   ARALAST 60mg/kg IV infusion viagravity0R	Ambulation 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) Line access documentation/verification if applicable   Nurse Orders: Nuse to provide assessment, teaching, lab draws, medication administration and vascular access documentation/fm 0R   100units/mL - 3-SmL flush after post-infusion ORS.   Flush Orders: Na/GU.9% - 5-10mL flush pre and post infusion ad as needed // Heparin   100units/mL0R   100units/mL -3-SmL flush after post-infusion NS flush if indicated to maintain line Lab Orders:   Lab Orders: Na/GU.9% - 5-10mL flush pre and post infusion ad as needed // Heparin   100units/mL -3-SmL flush after post-infusion NS flush if indicated to maintain line Lab Orders:   Anaphylaxis Kit: Epinephrine 0.3mg IM as needed Solu-ortef 250mg-500mg IV Infusion as needed Other   Pre-Medications: Accetaminophenmg P0minutes prior to infusion Other   Pre-Medications: Accetaminophenmg as needed NS Hydration 500 ml IV Infusionminutes prior to infusion Other   Supply Orders: All start dose? V No HNo, when was last dose given? When is patient due for next dose?   PRODUCT PRESCRIPTION INFORMATION REFILLS   Sthis a first dose? No If No, when was last dose given? When is patient due for next dose?   ARALAST 60mg/kg V infusion via   gravityOR   pump weekly over approximately 15 minutes   *Administer at arate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lat/batch   GutSSIA 60mg/kg V in	PLEASE ATTACH							
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.   Flush Orders: NaCl0.9% - 5-10mL flush pre and post infusion ad a needed Heparin -   10units/mLOR   100units/mL -3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders:   Anaphylaxis Kit:   Epinephrine 0.3mg IM as needed   Solu-cortef 250mg-500mg IV infusion as needed   0ther   Pre-Medications:   Acetaminophenmg P0minutes prior to infusionlong infusionminutes prior to infusiondotter   Pre-Medications:   Acetaminophenmg P0minutes prior to infusionlong infusionminutes prior to infusiondotter   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 his a first dose?  vs   No If No, when was last dose given?When is patient due for next dose?   ARALAST 60mg/kg IV infusion via   gravityOR   pump weekly over approximately 15 minutes "Administer at arate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch   OTHER NONE	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)       Line access documentation/verification if applicable							
Hush Orders: Norders: Norder: Norder: Norder: Norder: N								
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) Diphenhydraminemg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed Other   Pre-Medications: Acetaminophenmg P0minutes prior to infusion Solu-Medrolmg IV infusionminutes prior to infusion Other   Check all that apply) Diphenhydraminemg as needed P0OR IV infusionminutes prior to infusion Other   Supply Orders: All supply Solu-Audra access line care, drug administration kit(s), pump, and IV pole will be provided as necessary REFILLS   PRODUCT PRESCRIPTION INFORMATION REFILLS   Is this a first dose? Ves No If No, when was last dose given?When is patient due for next dose?   ARALAST 60mg/kg IV infusion via gravityOR grupp weekly over approximately 15 minutes *Acceptable allotment +/- 10% based on vial lot/batch   GLASSIA 60mg/kg IV infusion via gravityOR grupp weekly over approximately 15 minutes *Acceptable allotment +/- 10% based on vial lot/batch   GI OTHER NONE	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							
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) Diphenhydraminemg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed Other   Pre-Medications: Acetaminophenmg P0minutes prior to infusionminutes prior to infusionminutesminutesminutes prior to infusionminutes prior to infusionminutes prior to infusionminutesminutesminutes	PRESCRIPTION ORDERS							
(Check all that apply) Diphenhydramineng as needed POOR [IV infusionminutes prior to infusion Other   Supply Orders: All supple 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? Vs No If No, when was last dose given?When is patient due for next dose?   ARALAST 60mg/kg IV infusion via _ gravityOR 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								
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?         Is this a first dose?       Yes       No If No, when was last dose given?When is patient due for next dose?         Is this a first dose?       Yes       Is this a first dose?       Gomg/kg IV infusion via gravityOR 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								
Is this a first dose? Yes No If No, when was last dose given? When is patient due for next dose?   Is this a first dose? Yes No If No, when was last dose given? When is patient due for next dose?   Is this a first dose? 60mg/kg IV infusion via gravity 0R 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   Is GLASSIA 60mg/kg IV infusion via gravity 0R 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   Is other the formation of the exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch   Is other the formation of the exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch	Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary							
ARALAST <sup>60</sup> mg/kg IV infusion via gravity <i>OR</i> pump weekly over approximately 15 minutes <sup>*</sup> Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch <sup>60</sup> mg/kg IV infusion via gravity <i>OR</i> pump weekly over approximately 15 minutes <sup>*</sup> Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch <sup>60</sup> mg/kg IV infusion via gravity <i>OR</i> pump weekly over approximately 15 minutes <sup>*</sup> Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch <sup>O</sup> OTHER <sup>NONE</sup> <sup>NONE</sup> <sup>NONE</sup> <sup>NONE</sup> <sup>NONE</sup> <sup>O</sup> OTHER	PRODUCT		PRESCRIF	TION INFORMATI	ON		REFILLS	
ARALASI       *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 gravityOR grump 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	Is this a first dose? 🗆 Yes 📄 No If No, when was last dose given?When is patient due for next dose?							
GLASSIA       *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	🗆 ARALAST				% based on vial lot	/batch		
	🗆 GLASSIA							
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.	D OTHER						NONE	
	By signing this form an	d utilizing our services, you are authorizing	Amerita, Inc. to serve as	your prior authorization des	ignated agent in	n dealing with medical and prescription in	nsurance companies.	

Prescriber's Signature **Dispense as Written** 

Print Name

Date

Prescriber's Signature **Substitution Permitted** 

Print Name



Date