

# Alpha-1 Referral Form

Fax Completed Form To: 877-418-4495 Phone: 877-418-4114



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			
<b>Type of MS:</b> Primary progressive multiple sclerosis (PPMS) ---OR--- Relapsing multiple sclerosis (RMS)			
<b>Ambulation status:</b> Able to ambulate more than 5 meters Able to ambulate without aid or rest for at least 100 meters			
<b>Relapse details:</b> 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			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.			
<b>Flush Orders:</b> 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			
<b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>			
PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b> (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
<b>Pre-Medications:</b> (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
<b>Supply Orders:</b> 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
<b>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.</b>			

Prescriber's Signature \_\_\_\_\_  
Dispense as Written

Print Name

Date

Prescriber's Signature \_\_\_\_\_  
Substitution Permitted

Print Name

Date