

Alpha-1 Referral Form

Fax Completed Form To: 844-815-2606



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 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
Pre-Medications: (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
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
---	-------------------	-------------	--	-------------------	-------------

