Advanced Infusion Care®

Alpha-1 Proteinase Inhibitor Referral Form

212 Northside Drive, Valdosta, GA 31602

Phone: 800.482.8466 | Fax: 844.259.0209

www.aiscaregroup.com

Important: For expedited processing, please include the following with completed referral form:

- ☐ Insurance information (copy of ALL insurance cards, front and back)
- ☐ H&P with recent progress notes (signed)
- ☐ Serum AAT with genotype
- ☐ PFTs
- ☐ Chest x-ray
- ☐ Serum IgA level (if available)
- ☐ Medication list (current)
- ☐ Signed smoking cessation/ non-smoker attestation

Note: Please fax the completed referral form to the number listed above.

Alpha-1 Proteinase Inhibitor Referral Form

Fax completed form, insurance information, and clinical documentation to 844.259.0209.

If you have any questions or need assistance, please call 800.482.8466.

PATIENT DEMOGRAPHIC INFORMATION

Patient name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cellular phone: _____ Work phone: _____

Height: _____ Weight: _____ ☐ kg ☐ lbs

Known allergies?: ☐ Yes ☐ No If yes, please list: _____

Emergency contact name: _____ Emergency contact phone: _____

DIAGNOSIS AND THERAPY HISTORY

Primary *ICD-10* code: _____ ☐ E88.01 Alpha-1 antitrypsin deficiency ☐ Other: _____

Has the patient ever received Alpha-1 (augmentation) therapy? ☐ Yes ☐ No

If yes, which one?: ☐ Aralast® ☐ Glassia® ☐ Prolastin® ☐ Zemaira® Last dose given: _____ Next dose due: _____

Smoking history: ☐ Yes ☐ No Date stopped (if applicable): _____

Concurrent meds: _____

Vascular access: ☐ Peripheral ☐ Central ☐ Port

PRESCRIPTION INFORMATION

MEDICATION	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aralast®	☐ 60 mg/kg x _____ kg (pt weight) = total dose _____ mg once every week ☐ Other _____ mg/kg x _____ kg (pt weight) = total dose _____ mg once every _____ week **As tolerated by patient, not to exceed 0.2 mL per kg per minute** **Acceptable allotment +/- 10% based on vial lot/batch**	Quantity: ☐ 4-week supply ☐ 12-week supply Refills: ☐ 1 year ☐ Other: _____
☐ Glassia®	☐ 60 mg/kg x _____ kg (pt weight) = total dose _____ mg once every week ☐ Other _____ mg/kg x _____ kg (pt weight) = total dose _____ mg once every _____ week **As tolerated by patient, not to exceed 0.2 mL per kg per minute** **Acceptable allotment +/- 10% based on vial lot/batch**	Quantity: ☐ 4-week supply ☐ 12-week supply Refills: ☐ 1 year ☐ Other: _____

Lab orders: _____

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Patient name: _____

PRESCRIPTION INFORMATION CONTINUED

Provide emergency meds as needed for severe allergic anaphylactic reaction and/or moderate allergic reaction. Complete below:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
Catheter ☐ PIV ☐ Port ☐ PICC	IV	Catheter Care/Flush—Only on drug admin days—SASH or PRN to maintain IV access and patency PIV—NS 2-3 mL PORT/PICC—NS 10 mL and heparin 100 units/mL 3-5 mL, and 10 mL sterile saline to access portacath
☐ Epinephrine (nurse required)	☐ IM ☐ SQ	☐ Adult 1 mg/mL, 0.3 mL (>30 kg/70 lbs) ☐ Peds 1 mg/mL, 0.15 mL (<30 kg/33-70 lbs) May repeat in 5-15 minutes x 1 time as needed; PRN severe allergic reaction—Call 911
☐ Diphenhydramine 50 mg/mL vial	☐ IV ☐ IM	☐ Adult 25 mg (0.5 mL) >30 kg ☐ Peds 1.25 mg/kg <30 kg May repeat in 5-15 minutes x 1 time as needed (MAX dose is 50 mg combined—DO NOT exceed 50 mg); PRN severe allergic reaction—Call 911
☐ Solu-Cortef 100 mg/2 mL Act-O-Vial	IV	Adult >30 kg Activate vial. Administer over 2-3 minutes
☐ Normal Saline	IV	☐ Adult >30 kg 500 mL KVO rate PRN anaphylaxis ☐ Peds <30 kg 250 mL KVO rate PRN anaphylaxis

☐ A visit from a skilled nurse is needed to establish venous access, administer medication, and assess general status and response to therapy. Visit frequency based on prescribed orders.

If a nurse will be required for therapy administration, the home health nurse will call for additional orders per state regulations.
ALL fields must be completed to expedite prescription fulfillment.

Prescriber: _____ Name of practice: _____

Office contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____ NPI#: _____

PRESCRIBER SIGNATURE REQUIRED: Authorizing Above Nursing and Prescription Orders (Stamp Signature not Allowed)

"Dispense As Written"/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute

Prescriber's Signature

_____

Date

_____

OR May Substitute/Product Selection Permitted/ Substitution Permissible

Prescriber's Signature

_____

Date

_____

CA, MA, NC, and PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**": _____