



# Alpha-1 Proteinase Inhibitor Referral Form

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212 Northside Drive, Valdosta, GA 31602

Phone: 800.482.8466 | Fax: 844.259.0209

[www.aiscaregroup.com](http://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 <b>As tolerated by patient, not to exceed 0.2 mL per kg per minute</b> <b>Acceptable allotment +/- 10% based on vial lot/batch</b>	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 <b>As tolerated by patient, not to exceed 0.2 mL per kg per minute</b> <b>Acceptable allotment +/- 10% based on vial lot/batch</b>	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**": \_\_\_\_\_