Alpha-1 proteinase inhibitor therapy referral form

Optum

Optum Infusion Pharmacy Phone: Fax:

✂ Please detach before submitting to a pharmacy – tear here.

Care specialist Name: Phone:

Patient information

☐ see attached ☐ PEDIATRIC (younger than 13 years or less than 45kg in weight).

Patient name: Gender: ○ M ○ F DOB: Last 4 of SSN:

Address: City: State: ZIP:

Phone: Cell:

Emergency contact: Phone: Relationship:

Insurance ☐ Front and back of insurance card to follow

Primary Insurance: Phone: Policy #: Group:

Secondary Insurance: Phone: Policy #: Group:

Primary diagnosis ☐ ICD-10 code: Diagnosis:

☐ Other:

Medical assessment Height in inches: Weight **in kg only**: Date weight (in kg) obtained:

Current medications? ○ Yes ○ No If yes, list or attach:

Allergies:

Smoking status ○ Current ○ Past ○ Never Genotype (if tested)

Attach supportive clinical documents including patient's current pulmonary status.

Prescription and orders

Medication infused per the drug PI recommended rate and via rate controlled device per therapy

Medication	Dose and directions
Aralast® NP	First Dose: ○ YES ○ NO If NO, indicate when next dose is needed: Date Due: ○ Infuse Aralast NP 60 mg/kg or mg (+/-15%) intravenously once weekly via a rate controlled device. ○ Infuse Aralast NP mg (+/-15%) intravenously once every weeks via a rate controlled device. Infuse over approximately 15 minutes at a rate not to exceed 0.2 mL/kg/min as tolerated by the patient. Dispense Aralast NP in quantity sufficient for 4 weeks supply or Refill x1 year unless otherwise noted for times, or prn until date of
Glassia®	First Dose: ○ YES ○ NO If NO, indicate when next dose is needed: Date Due: ○ Infuse Glassia 60 mg/kg or mg (+/-15%) intravenously once weekly via a rate controlled device. ○ Infuse Glassia mg (+/-15%) intravenously once every weeks via a rate controlled device. Infuse over approximately 15 minutes at a rate not to exceed 0.2 mL/kg/min as tolerated by the patient. Dispense Glassia in quantity sufficient for 4 weeks supply or Refill x1 year unless otherwise noted for times, or prn until date of
Zemaira®	First Dose: ○ YES ○ NO If NO, indicate when next dose is needed: Date Due: ○ Infuse Zemaira 60 mg/kg or mg (+/-15%) intravenously once weekly via a rate controlled device. ○ Infuse Zemaira mg (+/-15%) intravenously once every weeks via a rate controlled device. Infuse over approximately 15 minutes at a rate not to exceed 0.08 mL/kg/min as tolerated by the patient. Dispense Zemaira in quantity sufficient for 4 weeks supply or Refill x1 year unless otherwise noted for times, or prn until date of
Pre-Medications, x1 year **Administer 30 minutes prior to infusion**	☐ Acetaminophen: Adult & Pediatric >30kg: Dispense 325mg tablets #100 or 325mg/10.15mL UD oral solution #100. Administer 325mg PO. Pediatric 15-30kg: Dispense 160mg tablets #30 or 160mg/5ml oral solution 120mL. Administer 160mg PO. May repeat x1 if symptoms occur. ☐ DiphenhydrAMINE: Adult & Pediatric >30kg: Dispense 25mg capsules or tablets #100. Administer 50mg PO. May repeat x1 if symptoms occur. Pediatric 15-30kg: Dispense 25mg/10mL oral solution 120 mL. Administer 25mg PO. May repeat once if symptoms occur. ☐ Other (specify):

This form is not a valid prescription in Arizona or New York.

Alpha-1 proteinase inhibitor therapy referral form

Optum

Optum Infusion Pharmacy Phone: Fax:

✂ Please detach before submitting to a pharmacy – tear here.

Patient name: DOB:

Ancillary orders

Lab Orders, x1 year	Specific lab(s) for nurse to draw Frequency Lab work to be obtained via IV access using aseptic technique. If RN is not able to draw labs via central catheter, RN may draw labs peripherally. RN to flush IV access after each blood draw with Sodium Chloride 0.9% 20 mL. As final lock for patency, use Heparin 10units/mL, 5mL, or if Port use Heparin 100units/mL, 5mL.
Nursing Orders, x1 year	RN to insert peripheral IV or access central catheter. RN to administer prescribed medication. RN to flush IV with Sodium Chloride 0.9%, 5mL pre-infusion and 5mL post infusion. If port access, flush with Sodium Chloride 0.9% 10mL pre-infusion and 10mL post-infusion. As a final lock for patency RN to use heparin 10 unit/mL, 3mL or if port, lock with heparin 100 units/mL, 5mL. RN to assess and instruct patient/caregiver in all aspects of medication administration, IV access device, disease process, and signs and symptoms of complications..
Pharmacy Orders, x1 year	Pharmacy to dispense flushes, needles, syringes and HME/DME quantity sufficient to complete therapy as prescribed.

☐ **Anaphylaxis management** x1 year (**Select check box to order**)

For Anaphylaxis ***Call 911***	• Stop infusion and remove infusion set needle from body to prevent further administration of causative drug • Administer contents of EPINEPHrine auto injector (pen) as an IM injection into the lateral thigh • Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrive • Notify prescribing physician after EMS care is received and condition is stable Pharmacy to dispense weight appropriate EPINEPHrine autoinjector #2 as follows. • For patient weight >30kg, EPINEPHrine dose 0.3mg/0.3mL • For patient weight 15-30kg, EPINEPHrine dose 0.15mg/0.15mL

Physician information

Name: Practice:

Address: City: State: ZIP:

Phone: Fax: NPI: Contact:

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible signature Dispense as written signature Date

Please fax: ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and labs, as applicable

Please include ALL pages when faxing

This form is not a valid prescription in Arizona or New York.