Alpha-1 proteinase inhibitor therapy referral form

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 New York.

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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

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