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

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: ☐ ICD10 Code: _____ Diagnosis: _____

Medical assessment: Height: _____ Weight: _____ ○ lbs ○ kg Genotype (if tested) _____

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

Allergies: _____

Smoking status: ○ Current ○ Past ○ Never

Attach chart/clinical notes regarding the patient's current pulmonary status and over all health. ☐

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 _____ 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 _____ 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 _____ times, or prn until date of _____
Pre-Medications, x1 year	Starting 30 minutes prior to infusion, patient may premedicate with the following: ☐ Acetaminophen ○ 325mg PO ○ 650mg PO ○ _____ mg PO May repeat every 4 to 6 hours as needed. Max 4,000 mg/day. ☐ DiphenhydrAMINE ○ 25mg PO ○ 50mg PO ○ _____ mg PO May repeat every 4 to 6 hours as needed. Max: 300 mg/day. ☐ Other _____

This form is not a valid prescription in Arizona.

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Patient name: _____ DOB: _____

Prescription and orders

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

Orders	Dose and directions
Lab Orders, x1 year	☐ Specific lab(s) for nurse to draw _____ Frequency _____ Lab work to be obtained via IV access using aseptic technique. RN may draw labs peripherally. RN to flush IV access after each blood draw with Sodium Chloride 0.9% 20 mL.
Nursing Orders, x1 year	Nursing to administer prescribed medication and establish and/or maintain IV access device. IV access to be flushed by nurse: • Sodium Chloride 0.9%: 5mls pre-infusion and 5mls post infusion • If Port access: Sodium Chloride 0.9%, 10mls pre-infusion and 10mls post-infusion followed by Heparin 100 units/ml, 5mls as final lock for patency 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 Kit Order** Infusion Reaction Management x1 year

Mild	• Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated. ☐ DiphenhydrAMINE PO ○ 25mg ○ 50mg _____ mg Dispense diphenhydrAMINE 25mg capsules x 4
Moderate	• Stop Infusion, resume at 50% rate when symptoms resolve ☐ DiphenhydrAMINE IV ○ 25mg ○ 50mg ○ _____ mg Dispense diphenhydrAMINE 50mg vial x 1
Severe (Anaphylaxis) ***Call 911*** **Notify prescribing physician**	• Stop infusion and remove tubing from access device to prevent further administration • Initiate 0.9% NaCl 500ml/hr IV OR _____ ml/hr • **Administer EPINEPHrine 1mg/ml by weight (Wt.) as an IM injection into the lateral thigh** Wt > 66lbs (30kg) 0.3mg/0.3ml — Wt 33 to 66 lbs (15 to 30kg) 0.15mg/0.15ml — Wt < 33lbs (15kg) 0.01mg/kg • Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrive ☐ Dispense 0.9% NaCl 500ml x1 ☐ Dispense EPINEPHrine x 2 ☐ 1mg vial ☐ Pen 0.3mg ☐ Pen JR 0.15mg ☐ Other medication: _____

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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