Please fax both pages of completed form to your drug therapy team at 866.233.7151.

To reach your team, call toll-free 866.6ALPHA.1 or 866.625.7421.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Alpha-1

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

Patient's first name ______________________________ Last name ______________________________ Middle initial ______

❑ Male ❑ Female Last 4 digits of SSN ______________________________ Date of birth ______________________________

Street address ______________________________ Apt # __________

City ______________________________ State ______________________________ Zip ______________________________

Home phone ____________________ Cell phone ____________________ E-mail address ______________________________

Parent/guardian (if applicable) ______________________________

Home phone ____________________ Cell phone ____________________ E-mail address ______________________________

Alternate caregiver/contact ______________________________

Home phone ____________________ Cell phone ____________________ E-mail address ______________________________

❑ OK to leave message with alternate caregiver/contact

Patient's primary language: ❑ English ❑ Other If other, please specify ______________________________

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date ____________________ Time ____________________ Date medication needed ______________________________

Prescriber's first name ______________________________ Last name ______________________________

Prescriber's title ______________________________ If NP or PA, under direction of Dr. ______________________________

Office address ______________________________

Office contact and title ______________________________

Office contact phone number ______________________________ Office contact e-mail ______________________________

Office/Infusion clinic name ______________________________ Office/Infusion clinic affiliation ______________________________

Street address ______________________________ Suite # __________

City ______________________________ State ______________________________ Zip ______________________________

Phone ____________________ Fax ____________________ NPI # ____________________ License # ____________________

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic Clinic location ______________________________

3 Clinical Information

Primary ICD-10 code: ______________________________ ❑ **E88.01 Alpha-1 antitrypsin deficiency**

Weight __________ kg/lbs Date recorded ______________ Has the patient ever received augmentation therapy? ❑ Yes ❑ No

If yes, which one: ❑ Aralast® ❑ Prolastin® ❑ Zemaira ❑ Glassia® Smoking history: ❑ Yes ❑ No If yes, date stopped ______________

❑ NKDA ❑ Known drug allergies ______________________________

Concurrent meds ______________________________

Vascular access: ❑ Peripheral ❑ Central ❑ Port

Please attach/send the following clinical documentation:

- History and physical (signed)
- Serum AAT with genotype
- PFTs
- Lung imaging
- Non-smoker or smoking cessation program attestation (MD and patient signature)

Patient's first name ______________________ Last name _________________________ Middle initial ______ Date of birth _________

Prescriber's first name ______________________________ Last name ________________________________ Phone ________________

4 Prescribing Information

Medication	Dose	Directions
❑ Aralast-NP ❑ Glassia ❑ Zemaira	❑ Infuse 60mg per kg (+/– 10%) intravenously weekly (where clinically appropriate, round to the nearest vial size) ❑ Other regimen ______________________________	Infusion method: ❑ Gravity ❑ Pump Rate protocol: For Aralast-NP or Glassia: As tolerated by patient, not to exceed 0.2mL per kg per minute For Zemaira: As tolerated by patient, not to exceed 0.08mL per kg per minute

Premedication to be given 30 minutes prior to infusion: ❑ ____

Medications to be used as needed: *(please strike through if not required)*
❑ Lidocaine 4% applied topically to insertion site prior to needle insertion as needed for intravenous site pain
❑ Other ____

Adverse reaction medications: *(keep on hand at all times)*
Epinephrine 0.3mg auto-injector 2-pk for patients weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose; may repeat one time.
Epinephrine 0.15mg auto-injector 2-pk for patients weighing less than 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose; may repeat one time.
Diphenhydramine 25mg by mouth for mild allergic reactions and 50mg for moderate-severe.

Flushing orders: Normal saline 3mL intravenous (peripheral line) or 10mL intravenous (central line) before and after infusion, or as needed for line patency
Heparin 10 units per mL 3mL intravenous (peripheral line) as final flush
Heparin 100 units per mL 5mL intravenous (central line) as final flush

Supplies: *(please strike through if not required)*
Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

Quantity/Refills Dispense 1 month supply. Refill x 1 year unless noted otherwise.
❑ Dispense 90 day supply. Refill x 1 year unless noted otherwise.
❑ Other ____

Lab orders ____

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. Visit frequency based on prescribed orders.

*If nursing services 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.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature (sign below) **(Physician attests this is his/her legal signature. NO STAMPS)** **PHYSICIAN SIGNATURE REQUIRED**

SIGN HERE

________________ ________________________________ ________________ ________________________________
Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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Prior Authorization Checklist
Alpha-1 Antitrypsin (AAT) Deficiency (Alpha-1)

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients with Alpha-1. Coverage criteria may vary by payer.

	Referral Form (not required for electronic prescriptions)
	Completed Alpha-1 referral form (available at accredo.com)
	Copies of front and back of medical insurance and prescription benefit cards

	Clinical Documents
	History and Physical (Signed) — with documentation of emphysema
	Pulmonary Function Tests (PFTs)
	Serum AAT
	Phenotype
	Lung imaging
	Testing for presence/absence of immunoglobulin A (IgA) antibody
	Attestation of non-smoking status or smoking cessation treatment by physician and patient

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.6ALPHA.1 (866.625.7421).

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