Prescription & Enrollment Form

Alpha-1

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Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name ____________________

Last name ____________________ Middle initial ____

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

Street address ____________________ Apt # ______

City ____________________ State ______ Zip __________

Parent/guardian (if applicable) ____________________

Home phone ______________ Work phone ______________

Cell phone ______________ Evening phone ______________

E-mail address ____________________

Patient's primary language: ❑ English ❑ Other

If other, please specify ____________________

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company ____________________ Phone __________

Insured's name ____________________

Insured's employer ____________________

Relationship to patient ____________________

Identification # ______________ Policy/group # ______________

Prescription card: ❑ Yes ❑ No If yes, carrier ____________________

Policy # ______________ Group # ______________

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date __________ Time __________ Date medication needed __________

Prescriber's first name ____________________

Prescriber's last name ____________________

Prescriber's title ____________________

If NP or PA, under direction of Dr. ____________________

Office contact and title ____________________

Office contact e-mail ____________________

Clinic/hospital 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

Current weight __________ ❑ lb ❑ kg 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)

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.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

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

PHYSICIAN SIGNATURE REQUIRED

__________ ____________________ __________ ____________________
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.

Please fax 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.

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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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