

### 1 PATIENT INFORMATION

Patient's name \_\_\_\_\_  
 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 \_\_\_\_\_  
 Insurance company name \_\_\_\_\_  
 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 **Please attach front and back copy of patient's insurance cards, if available.**

### 2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_  
 Prescriber's name and title \_\_\_\_\_  
 Office contact \_\_\_\_\_  
 Clinic/hospital affiliation \_\_\_\_\_  
 Street address \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 NPI # \_\_\_\_\_ License # \_\_\_\_\_  
 DEA # \_\_\_\_\_  
 Physician Medicaid UPIN # \_\_\_\_\_  
 MD specialty \_\_\_\_\_

To reach your team, call toll-free at 1 866 6Alpha-1 or 1 866 625 7421.  
 Please fax the completed form to the Zemaira team at 1 866 233-7151.



### 3 CLINICAL INFORMATION

Primary ICD-9 code \_\_\_\_\_  
**Medical information**  
 Primary diagnosis \_\_\_\_\_ Current weight \_\_\_\_\_  lb  kg Date recorded \_\_\_\_\_ Diabetic  Yes  No  
 Antitrypsin deficiency blood testing completed?  Yes  No IgA Level \_\_\_\_\_  
 Has the patient ever received augmentation therapy?  Yes  No  
 If yes, which one  Aralast®  Prolastin®  Zemaira  Glassia®  
 Associated medical conditions \_\_\_\_\_  
 Serum AAT level \_\_\_\_\_ mg/dL OR \_\_\_\_\_ pM Date \_\_\_\_\_  
 PFT FEV % pred. \_\_\_\_\_ O2 therapy \_\_\_\_\_ L/min Date \_\_\_\_\_  
 CXR/CT results \_\_\_\_\_ Date \_\_\_\_\_  
 Phenotype  PiZZ  PiSZ  PiMZ  Other \_\_\_\_\_  
 Smoking history  Yes  No If previous smoker, date stopped \_\_\_\_\_  
 Notes \_\_\_\_\_

#### Medication orders

Alpha-1 product  Zemaira Refills  1 year or  \_\_\_\_\_ (as allowed by state or payer requirements)  
 Dosage  60 mg per kg (+/-10%) weekly  Other regimen \_\_\_\_\_  
 Vascular access device  
 Peripheral catheter  Central catheter Type \_\_\_\_\_ # of lumens \_\_\_\_\_  
 Delivery method  Gravity  As tolerated by patient, not to exceed 0.08 mL per kg per minute  
 Other \_\_\_\_\_  Premedication \_\_\_\_\_  
 ELA-Max 4% 5 grams applied topically to site prior to venous accessing  
 Is this the first dose?  Yes  No If no, date first dose given \_\_\_\_\_ Next dose \_\_\_\_\_  
 Skilled nursing visit to establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed, and assess general status and response to therapy. Visit frequency based on prescribed dosage orders.\*

#### Flush orders

Peripheral — Flush with 1–50 mL NS before and after IV, followed by 3–5 mL heparin 10 units per mL as final flush prn  
 Central — Flush with 1–50 mL NS before and after IV, followed by 3–5 mL heparin 100 units per mL as final flush  
 Anaphylaxis kit in the patient's home  
 Diphenhydramine 25–50 mg PO prn allergic reaction  EpiPen® 0.3 mg IM prn anaphylaxis  
 Dispense a 1-month supply of medication, needles, syringes, ancillary supplies, and HME necessary to establish access and administer medication. Refills 1 year.  
 NKDA  Known drug allergies \_\_\_\_\_  
 Deliver product to  Office  Patient's home  Clinic/clinic location

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

Additional requirements \_\_\_\_\_

By signing below, I certify that the above therapy is medically necessary.

Prescriber's printed name \_\_\_\_\_

Prescriber's signature (sign below) \_\_\_\_\_

Dispense as written \_\_\_\_\_

Date \_\_\_\_\_

(Prescriber attests this is his/her legal signature. NO STAMPS)