

**Patient
Demographic
Information**

Patient Name (First/Last) _____ Date of Birth (DOB) _____
Address _____
City _____ State _____ ZIP _____ Home Phone _____

**Insurance
Information
(Attach Card)**

Primary Insurance _____
Phone _____
Subscriber _____ DOB _____ Subscriber ID # _____ Policy/Group # _____
Secondary/Medigap _____ Phone _____
Subscriber _____ DOB _____ Subscriber ID # _____ Policy/Group # _____
Medicare Part D Yes No Phone: _____
Subscriber _____ DOB _____ Subscriber ID # _____ Policy/Group # _____
Benefit Check (Do not contact patient)

**Diagnosis/
Medical
Assessment**

Primary Diagnosis: _____ Alpha₁-Antitrypsin Deficiency ICD.9 Code 273.4
Associated Medical Conditions: _____ ICD.9 Code _____
Serum AAT Level: _____ mg/dL OR _____ µM Date: _____
PFT: FEV₁ % 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: _____

Therapy

Prescribed Therapy: ARALAST NP [alpha₁-proteinase inhibitor (human)]
Patient Weight: _____ kg (2.2 lb = 1 kg) Ordered Dose: _____ mg Frequency: Weekly Other _____
Dosing: The recommended dosage of ARALAST NP is 60 mg/kg body weight administered once weekly.
Refills (Months): _____
Infusion Location: Home Hospital Physician Office Infusion Center
Please enter your preferred Specialty Pharmacy here: _____
Preferred Hospital: _____
Is patient aware of diagnosis and treatment? Yes No

Prescriber

Physician Name _____ License # _____
Address _____ NPI # _____
City _____ State _____ ZIP _____ DEA # _____
Phone _____ Fax _____ Office Contact _____
Signature _____ Date _____

I certify that the prescribed therapy is medically necessary for the treatment of Alpha₁-antitrypsin deficiency and that the above information is accurate to the best of my knowledge and belief. I further certify that I have obtained the patient's consent to release this information for the patient's enrollment in the ARALAST NP AATmosphere program. By my signature above, I authorize the ARALAST NP AATmosphere program to (1) provide any information on this form to the insurer of the above named patient for enrollment/verification purposes and (2) forward the above prescription information, by fax or other mode of delivery, to the patient's pharmacy. I understand that any information released will be used only for the purposes for which it has been provided.

ARALAST NP [Alpha₁-Proteinase Inhibitor (Human)] is indicated for chronic augmentation therapy in patients having congenital deficiency of A₁-PI with clinically evident emphysema. ARALAST NP is not indicated as therapy for lung disease patients in whom congenital A₁-PI deficiency has not been established.

Important Safety Information

- ARALAST NP is contraindicated in individuals with selective IgA deficiencies (IgA level less than 15 mg/dL) who have known antibody against IgA, since they may experience severe reactions, including anaphylaxis to IgA, which may be present in small quantities in the final drug product.
- ARALAST NP is derived from pooled human plasma. It may carry a risk of transmitting infectious agents, e.g. viruses, and theoretically, the Creutzfeldt-Jakob disease (CJD) agent.
- The most common adverse events deemed related to ARALAST NP included: headache (4 of 61 [7%] events) and musculoskeletal discomfort (4 of 61 [7%] events).

Please see enclosed ARALAST NP Prescribing Information for full prescribing details.