Prescription & Enrollment Form

Alpha-1

Four simple steps to submit your referral.

accredo®

677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

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.

PHYSICIAN SIGNATURE REQUIRED

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

_____ _____ _____ _____
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 808.650.6487. To reach your team, call toll-free 866.6ALPHA.1 or 808.650.6488.

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