Please fax all pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 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.

Prescription & Enrollment Form

Alpha-1

accredo®

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

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

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

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ ☐ **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	Strength/Formulation	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 required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

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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