

Alpha-1 Referral Form

Fax Completed Form To:

Phone:



PATIENT INFORMATION			
Patient Name:		Date of Birth:	Referral Date:
Address:		City/State/Zip:	
Home Phone:	Cell Phone:		Work Phone:
Secondary Contact:	Height:	Weight:	☐ Male ☐ Female
Patient Diagnosis & ICD-10:			
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	DEA #:
Practice Name:		NPI#:	
Address:		City/State/Zip:	
Office Contact:	Phone:		Fax:
Supervisory Physician (if applicable):			
MS CLINICAL DETAILS			
Type of MS: ☐ Primary progressive multiple sclerosis (PPMS) ---OR--- ☐ Relapsing multiple sclerosis (RMS) Ambulation status: ☐ Able to ambulate more than 5 meters ☐ Able to ambulate without aid or rest for at least 100 meters Relapse details: ☐ Two or more relapses within the previous two years ☐ One relapse within the previous year			
PLEASE ATTACH			
☐ Patient demographics & front/back copy of all insurance cards (prescription & medical) ☐ Recent office visit notes, history & physical, lab & pertinent procedure results ☐ Current medication list & list of prior medications tried and failed (with dates)		☐ Alpha-1 antitrypsin levels, FEV1 score, & smoking status ☐ Line access documentation/verification if applicable ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
NURSING & LAB ORDERS			
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - ☐ 10units/mL ---OR--- ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders: Lab Date & Frequency:			
PRESCRIPTION ORDERS			
Anaphylaxis Kit: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) ☐ Diphenhydramine _____mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other			
Pre-Medications: ☐ Acetaminophen _____mg PO _____minutes prior to infusion ☐ Solu-Medrol _____mg IV infusion _____minutes prior to infusion (Check all that apply) ☐ Diphenhydramine _____mg as needed ☐ PO ---OR--- ☐ IV infusion _____minutes prior to infusion ☐ Other			
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given? _____ When is patient due for next dose? _____			
☐ ARALAST	60mg/kg IV infusion via ☐ gravity ---OR--- ☐ pump weekly over approximately 15 minutes *Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch		
☐ GLASSIA	60mg/kg IV infusion via ☐ gravity ---OR--- ☐ pump weekly over approximately 15 minutes *Administer at a rate not to exceed 0.2 mL/kg body weight per minute **Acceptable allotment +/- 10% based on vial lot/batch		
☐ OTHER			NONE
<i>By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.</i>			

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date



ACHC
ACCREDITED

