

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)	☐ Alpha-1 antitrypsin levels, FEV1 score, & smoking status	
☐ Recent office visit notes, history & physical, lab & pertinent procedure results	☐ Line access documentation/verification if applicable	
☐ Current medication list & list of prior medications tried and failed (with dates)	☐ 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
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.		

Prescriber's Signature
Dispense as Written

Print Name _____

Date _____

Prescriber's Signature
Substitution Permitted

Print Name _____

Date _____