Alpha$_1$ Proteinase Inhibitor Deficiency Enrollment Form

(Aralast, Glassia)

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813
Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________ DOB: ______________
Address: ______________________ City, State, ZIP Code: ______________
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: ______________________ Alternate Phone: ______________
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): ______________
Relationship to minor: ______________
Email: ______________ Last Four of SSN: ________ Primary Language: ______________

2 PRESCRIBER INFORMATION

Prescriber's Name: ______________________ State License #: ______________
NPI #: ______________ DEA #: ______________ Group or Hospital: ______________
Address: ______________________ City, State, ZIP Code: ______________
Phone: ______________ Fax______________ Contact Person: ______________ Contact's Phone: ______________

3 INSURANCE INFORMATION
Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: ______________ Ship to: ☐ Patient ☐ Office ☐ Other: ______________

Diagnosis (ICD-10):
☐ E88.01 (Congenital Emphysema) Alpha$_1$-Antitrypsin Deficiency ☐ Other Code: ________ Description ______________

Patient Clinical Information:
Allergies: ______________ Weight: _____lb/kg Height: _____in/cm Phenotype: ______________
FEV1 ________% predicted Serum A1AT levels (pretreatment) ______ mg/dL or ______ microM
Does the patient display clinically evident emphysema? ☐ Yes ☐ No

Patient Clinical Documentation:
☐ Current medication profile ☐ History and physical (signed) ☐ Lung Imaging ☐ Hep B vaccine series complete/in progress
☐ Recent lab work showing negative TB test ☐ Non-smoker or smoking cessation program attestation (MD and patient signature)
☐ PFT ☐ Serum AAT with genotype

Therapy History:
First time receiving Alpha 1 therapy? ☐ Yes ☐ No
If No, previous product used:______________ Last Dose Given:______________ Next Dose Due: ______________

Lab Orders: ______________

Nursing: Specialty pharmacy to coordinate home health infusion nurse visit necessary ☐ Yes ☐ No

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aralast	☐ 60 mg/kg X _____ Kg (pt weight)= Total Dose ______ Mg once every week ☐ Other _____mg/kg x _____kg (pt weight) = Total Dose ____mg every ___ week ***Acceptable allotment +/- 10% based on vial lot/batch**	Quantity: ☐ 4-week supply ☐ 12-week supply Refills: ☐ 1 year ☐ Other: ________
☐ Glassia	☐ 60 mg/kg X _____ Kg (pt weight)= Total Dose ______ Mg once every week ☐ Other _____mg/kg x _____kg (pt weight) = Total Dose ____mg every ___ week ***Acceptable allotment +/- 10% based on vial lot/batch**	Quantity: ☐ 4-week supply ☐ 12-week supply Refills: ☐ 1 year ☐ Other: ________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature:** ______________ **Date:** ________	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature:** ______________ **Date:** ______

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ______________ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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Alpha$_1$ Proteinase Inhibitor Deficiency Enrollment Form

(Zemaira)

Please Complete Patient and Prescriber Information

Patient Name: ______________________________ Patient DOB: ______________________________

Prescriber Name: ______________________________ Prescriber Phone: ______________________________

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Zemaira	☐ 60 mg/kg X _____ Kg (pt weight)= Total Dose ______ Mg once every week ☐ Other _____mg/kg x _____kg (pt weight) = Total Dose ____mg every ___ week ***Acceptable allotment +/- 10% based on vial lot/batch**	Quantity: ☐ 4-week supply ☐ 12-week supply Refills: ☐ 1 year ☐ Other: _______

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
Catheter ☐ PIV ☐ PORT ☐ PICC	IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) ☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) ☐ Infant 0.1 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed
☐ Diphenhydramine Oral	PO	☐ 12.25 mg/kg (0-30kg) ☐ 25 mg ☐ 50 mg (Over 30 kg) PRN severe allergic reaction – Call 911
☐ Diphenhydramine 50mg/mL vial	☐ Slow IV ☐ IM	☐ 1 mg/kg (under 15 kg) ☐ 12.5-50 mg (15-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg) PRN severe allergic reaction – Call 911
☐ Other: ____________	☐ Other: ________	☐ Other: ______________________________
☐ Other: ____________	☐ Other: ________	☐ Other: ______________________________

Quantity: ☐ 1 cycle ☐ 1 month ☐ 3 months ☐ Other: ____________________ Refills: ☐ 1 year ☐ ____________________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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