Alpha$_1$ Proteinase Inhibitor Deficiency Enrollment Form

(Aralast, Glassia)

Fax Referral To: 1-888-280-1191 OR 787-759-4161
Phone: 1-888-280-1190 OR 787-759-4162
Email Referral To: Customer.ServiceFax@CVSHealth.com
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

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	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____**Date:** _____	**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.

©2022 CVS Pharmacy, Inc. or one of its affiliates. 75-35450K 03/14/22

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

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____Date: _____	**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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.