Pharmacy Name: Phone:
Address: Fax:
City/State/Zip: Email:

Alpha1 Therapy Referral Form

Patient Information PLEASE FAX INSURANCE CARD (FRONT AND BACK)				Prescriber Information		
Last Name	First Name	DOB		Practice/Facility Name		
Address				Address		
City	State	Zip		City	State	Zip
Phone	SSN			Prescriber Name		
Allergies		Latex Allergy Y N		Prescriber NPI		
Sex M F	Weight (kg)	Height (ft,in)		Nurse/Key Contact		
Insurance Plan				Phone/Pager		
Plan ID #				Fax	Email	

Diagnosis and Clinical Information

Diagnosis (ICD-10):
E88.01 (Congenital Emphysema) Alpha1-Antitrypsin Deficiency Other Code: Description:

Diagnosis (ICD-10):
Allergies:
FEV1: % predicted
Serum A1AT levels (pretreatment) md/dl or microM
Does the patient display clinically evident emphysema? Y N

Needs by Date: Ship to Patient Office Other:
Lab Orders:
Nursing: Please arrange nursing administration
Patient may be taught to self-infuse

Prescription Information

Medication	Dose and Directions		Quantity	Refills
☐ Glassia®	60mg/kg via IV infusion once every week other mg/kg via IV infusion once every week other		4 week supply 12 week supply	1 year
☐ Aralast®	60mg/kg via IV infusion once every week other mg/kg via IV infusion once every week other		4 week supply 12 week supply	1 year
☐ Prolastin-C®	60mg/kg via IV infusion once every week other mg/kg via IV infusion once every week other		4 week supply 12 week supply	1 year
☐ Epinephrine® IM SQ	Adult 1:1000, 0.3mL (>30kg/>66lbs) Peds 1:2000, 0.3mL (15-30kg/33-66lbs)	PRN Anaphylaxis Repeating Dose:	Once	1 year
Normal Saline D5W	3mL 5mL Other:	IV before and after infusion	1 month 3 months	1 year
Heparin 10 units/mL Heparin 100 units/mL	3mL 5mL Other:	IV before and after infusion	1 month 3 months	1 year
☐ Other:				
☐ Vascular Access Method:	Peripheral Central Other:			

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.

This is not a valid prescription in the state of Arizona.