

Alpha₁ Proteinase Inhibitor Deficiency Enrollment Form (Aralast, Glassia)



Fax Referral To: 1-866-843-3221 Phone: 1-866-899-1661
Email Referral To: NationalCoramCallCen@coramhc.com



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) Alpha₁-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
<input type="checkbox"/> Aralast	<input type="checkbox"/> 60 mg/kg X _____ Kg (pt weight) = Total Dose _____ Mg once every week <input type="checkbox"/> Other _____ mg/kg x _____ kg (pt weight) = Total Dose _____ mg every _____ week *Acceptable allotment +/- 10% based on vial lot/batch	Quantity: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Glassia	<input type="checkbox"/> 60 mg/kg X _____ Kg (pt weight) = Total Dose _____ Mg once every week <input type="checkbox"/> Other _____ mg/kg x _____ kg (pt weight) = Total Dose _____ mg every _____ week *Acceptable allotment +/- 10% based on vial lot/batch	Quantity: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> 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.

Alpha₁ 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
<input type="checkbox"/> Zemaira	<input type="checkbox"/> 60 mg/kg X _____ Kg (pt weight) = Total Dose _____ Mg once every week <input type="checkbox"/> Other _____ mg/kg x _____ kg (pt weight) = Total Dose _____ mg every _____ week <p style="text-align: center;">*Acceptable allotment +/- 10% based on vial lot/batch</p>	Quantity: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
Catheter <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> 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
<input type="checkbox"/> Epinephrine **nursing requires**	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) <input type="checkbox"/> 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
<input type="checkbox"/> Diphenhydramine Oral	PO	<input type="checkbox"/> 12.25 mg/kg (0-30kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg) PRN severe allergic reaction – Call 911
<input type="checkbox"/> Diphenhydramine 50mg/mL vial	<input type="checkbox"/> Slow IV <input type="checkbox"/> IM	<input type="checkbox"/> 1 mg/kg (under 15 kg) <input type="checkbox"/> 12.5-50 mg (15-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg) PRN severe allergic reaction – Call 911
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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 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.

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.