

## Humana Specialty Pharmacy®

Monday – Friday, 8 a.m. – 11 p.m., and  
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

### Alpha-1 Prescription Form

#### Patient information

Patient: \_\_\_\_\_  Female  Male DOB: \_\_\_\_\_ Insurance plan: \_\_\_\_\_ Plan ID #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Home phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_ Caregiver: \_\_\_\_\_ Caregiver phone #: \_\_\_\_\_  
 Other medical conditions: \_\_\_\_\_ Allergies:  No  Yes: \_\_\_\_\_

#### Clinical information

ICD-10 code: _____ Diagnosis date: _____ <input type="checkbox"/> Alpha-1 antitrypsin deficiency: E88.01 <input type="checkbox"/> Chronic obstructive pulmonary disease: J44.9 <input type="checkbox"/> Emphysema, unspecified: J43.9 <input type="checkbox"/> _____ Phenotype: <input type="checkbox"/> PiZZ <input type="checkbox"/> PiSZ <input type="checkbox"/> PiMZ _____ Associated conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes": <input type="checkbox"/> Diabetes <input type="checkbox"/> IgA deficiency <input type="checkbox"/> Liver disease <input type="checkbox"/> Renal disease Smoking history? <input type="checkbox"/> No <input type="checkbox"/> Yes Date stopped: _____ Previous augmentation therapy? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes": <input type="checkbox"/> Aralast NP <input type="checkbox"/> Glassia <input type="checkbox"/> Prolastin-C <input type="checkbox"/> Zemaira	AAT serum level: _____ <input type="checkbox"/> mg/dL <input type="checkbox"/> μM <input type="checkbox"/> G/L Date: _____ Chest X-ray/CT results: _____ Date: _____ FEV1/FVC: _____ Date: _____, O <sub>2</sub> therapy: _____ L/min First dose? <input type="checkbox"/> No <input type="checkbox"/> Yes Expected date of first/next infusion: _____ Site of care: <input type="checkbox"/> Home <input type="checkbox"/> MDO <input type="checkbox"/> Clinic: _____ Venous access: <input type="checkbox"/> PIV <input type="checkbox"/> PICC <input type="checkbox"/> Port <input type="checkbox"/> Central line, type: _____ Infusion method: <input type="checkbox"/> Gravity <input type="checkbox"/> Pump Height: _____ Weight: _____ lb <input type="checkbox"/> kg Date: _____
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#### Prescription information Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medications/supplies	Directions	Quantity	Refills
<input type="checkbox"/> Aralast NP <input type="checkbox"/> 60 mg/kg (+/-10%) <input type="checkbox"/> 120 mg/kg (+/-10%) <input type="checkbox"/> _____	<input type="checkbox"/> Infuse IV weekly <input type="checkbox"/> Infuse IV every two weeks <input type="checkbox"/> _____ Rate protocol: as tolerated by patient, not to exceed 0.2 mL/kg per min.	<input type="checkbox"/> 28-day supply <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Glassia <input type="checkbox"/> 60 mg/kg (+/-10%) <input type="checkbox"/> 120 mg/kg (+/-10%) <input type="checkbox"/> _____	<input type="checkbox"/> Infuse IV weekly <input type="checkbox"/> Infuse IV every two weeks <input type="checkbox"/> _____ Rate protocol: as tolerated by patient, not to exceed 0.2 mL/kg per min.	<input type="checkbox"/> 28-day supply <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Zemaira <input type="checkbox"/> 60 mg/kg (+/-10%) <input type="checkbox"/> 120 mg/kg (+/-10%) <input type="checkbox"/> _____	<input type="checkbox"/> Infuse IV weekly <input type="checkbox"/> Infuse IV every two weeks <input type="checkbox"/> _____ Rate protocol: as tolerated by patient, not to exceed 0.08 mL/kg per min.	<input type="checkbox"/> 28-day supply <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Skilled nursing visit to establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed and assess general status and response to therapy. Frequency based on prescription dose orders.			
Pretreatment: <input type="checkbox"/> acetaminophen <input type="checkbox"/> 325 mg tablet <input type="checkbox"/> 500 mg tablet <input type="checkbox"/> diphenhydramine <input type="checkbox"/> 25 mg capsule <input type="checkbox"/> 50 mg tablet	<input type="checkbox"/> Take _____ mg p.o. 30–60 min. prior to inf. and q4–6 p.r.n. Max. four doses in 24 hr. <input type="checkbox"/> _____	<input type="checkbox"/> 10 capsules <input type="checkbox"/> 10 tablets <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
Anaphylactic treatment: <input type="checkbox"/> diphenhydramine <input type="checkbox"/> 50 mg/mL vial <input type="checkbox"/> 25 mg capsule <input type="checkbox"/> 50 mg tablet	<input type="checkbox"/> Infuse slowly IV p.r.n. anaphylaxis <input type="checkbox"/> Take 25–50 mg p.o. p.r.n. anaphylaxis	<input type="checkbox"/> 1 vial <input type="checkbox"/> 10 capsules <input type="checkbox"/> 10 tablets	<input type="checkbox"/> 0 <input type="checkbox"/> _____
Anaphylactic treatment: <input type="checkbox"/> epinephrine <input type="checkbox"/> 0.3 mg auto-injector <input type="checkbox"/> 0.15 mg auto-injector (for patients weighing 15–30 kg)	Inject IM p.r.n. anaphylaxis	<input type="checkbox"/> 2-pack <input type="checkbox"/> _____	<input type="checkbox"/> 0 <input type="checkbox"/> _____
<input type="checkbox"/> lidocaine 2.5% and prilocaine 2.5% cream	Apply topically to needle insertion site 30–60 min. prior to insertion	<input type="checkbox"/> 28-day supply <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> sodium chloride 0.9% 10 mL flush	Flush line with 10 mL before and after inf. and p.r.n. line care	<input type="checkbox"/> 28-day supply <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> heparin 100 U/mL 5 mL PFS (for central line patients)	Flush line with 5 mL after final saline flush	<input type="checkbox"/> 28-day supply <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____

Pharmacy to dispense ancillary supplies as needed to establish IV and administer drug.

#### Prescriber and shipping information (please print)

Prescriber: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Ship to:  Patient  Office  Other: \_\_\_\_\_ Office phone number: \_\_\_\_\_ Office fax number: \_\_\_\_\_  
 Office address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: \_\_\_\_\_  
 The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state specific prescription form and fax language.  
 Noncompliance with state-specific requirements could result in outreach to the prescriber.

