Fax: 877-405-7940
Phone: 800-486-2668

CenterWell 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: Please Include History and Physical (H&P) and latest visit note including infection history/treatment for past 6 months

ICD-10 code: ❒ Alpha-1 antitrypsin deficiency: E88.01 ❒ Chronic obstructive pulmonary disease: J44.9 ❒ Emphysema, unspecified: J43.9 ❒ _____
Diagnosis date: _____ Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____

Phenotype: ❒ PiZZ ❒ PiSZ ❒ PiMZ _____ Associated conditions? ❒ No ❒ Yes If "Yes": ❒ Diabetes ❒ IgA deficiency ❒ Liver disease ❒ Renal disease
Smoking history? ❒ No ❒ Yes Date stopped: _____ FEV1/FVC: _____ Date: _____, O_2 therapy: _____L/min
Previous augmentation therapy? ❒ No ❒ Yes If "Yes": ❒ Aralast NP ❒ Glassia ❒ Prolastin-C ❒ Zemaira
AAT serum level: _____ ❒ mg/dL ❒ µM ❒ G/L Date: _____ Chest X-ray/CT results: _____ Date: _____

First dose? ❒ No ❒ Yes Expected date of first/next infusion: _____ Site of care: ❒ Home ❒ MDO ❒ Clinic: _____
Venous access: ❒ PIV ❒ PICC ❒ Port ❒ Central line, type: _____ Infusion method: ❒ Gravity ❒ Pump

❒ 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.

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
❒ Aralast NP ❒ 60 mg/kg (+/-10%) ❒ 120 mg/kg (+/-10%) ❒ _____	❒ Infuse IV weekly ❒ Infuse IV every two weeks ❒ _____ Rate protocol: as tolerated by patient, not to exceed 0.2 mL/kg per min.		❒ 28-day supply ❒ _____	❒ 11 ❒ _____
❒ Glassia ❒ 60 mg/kg (+/-10%) ❒ 120 mg/kg (+/-10%) ❒ _____	❒ Infuse IV weekly ❒ Infuse IV every two weeks ❒ _____ Rate protocol: as tolerated by patient, not to exceed 0.2 mL/kg per min.		❒ 28-day supply ❒ _____	❒ 11 ❒ _____
❒ Zemaira ❒ 60 mg/kg (+/-10%) ❒ 120 mg/kg (+/-10%) ❒ _____	❒ Infuse IV weekly ❒ Infuse IV every two weeks ❒ _____ Rate protocol: as tolerated by patient, not to exceed 0.08 mL/kg per min.		❒ 28-day supply ❒ _____	❒ 11 ❒ _____
Pretreatment: ❒ acetaminophen ❒ 325 mg tablet ❒ 500 mg tablet ❒ diphenhydramine ❒ 25 mg capsule ❒ 50 mg tablet	❒ Take _____mg p.o. 30–60 min. prior to inf. and q4–6 p.r.n. Max. four doses in 24 hr. ❒ _____		❒ 10 capsules ❒ 10 tablets ❒ _____	❒ 11 ❒ _____
Anaphylaxis Kit (Patient's home):	❒ Epinephrine 0.3 mg auto-injector	❒ Inject IM p.r.n. anaphylaxis	❒ 2-pack	❒ 0 ❒ _____
	❒ Epinephrine 0.15 mg auto-injector (patients 15–30 kg)	❒ Inject IM p.r.n. anaphylaxis	❒ 2-pack	
	❒ Diphenhydramine 25 mg capsules	❒ Take 25–50 mg PO p.r.n. anaphylaxis	❒ 10 capsules	
	❒ Diphenhydramine 50 mg/mL injection	❒ Inject slow IV push p.r.n anaphylaxis	❒ 1 vial	
❒ lidocaine 2.5% and prilocaine 2.5% cream	Apply topically to needle insertion site 30–60 min. prior to insertion		❒ 28-day supply ❒ _____	❒ 11 ❒ _____
❒ sodium chloride 0.9% 10 mL flush	Flush line with 10 mL before and after inf. and p.r.n. line care		❒ 28-day supply ❒ _____	❒ 11 ❒ _____
❒ heparin 100 U/mL 5 mL PFS (for central line patients)	Flush line with 5 mL after final saline flush		❒ 28-day supply ❒ _____	❒ 11 ❒ _____

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.