Fax: 877-405-7940
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CenterWell Specialty Pharmacy

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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: ______________
❒ Alpha-1 antitrypsin deficiency: E88.01
❒ Chronic obstructive pulmonary disease: J44.9
❒ Emphysema, unspecified: J43.9
❒ ________________________
Phenotype: ❒ PiZZ ❒ PiSZ ❒ PiMZ ______________
Associated conditions? ❒ No ❒ Yes
If "Yes": ❒ Diabetes ❒ IgA deficiency ❒ Liver disease ❒ Renal disease
Smoking history? ❒ No ❒ Yes Date stopped: ______________
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: ______________
FEV1/FVC: __________ Date: ________, O_2 therapy: __________L/min
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
Height: _________ Weight: _______ ❒ lb ❒ kg Date: __________

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 ❒ _____
❒ 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: ❒ 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 ❒ _____
Anaphylactic treatment: ❒ diphenhydramine ❒ 50 mg/mL vial ❒ 25 mg capsule ❒ 50 mg tablet	❒ Infuse slowly IV p.r.n. anaphylaxis ❒ Take 25–50 mg p.o. p.r.n. anaphylaxis	❒ 1 vial ❒ 10 capsules ❒ 10 tablets	❒ 0 ❒ _____
Anaphylactic treatment: ❒ epinephrine ❒ 0.3 mg auto-injector ❒ 0.15 mg auto-injector (for patients weighing 15–30 kg)	Inject IM p.r.n. anaphylaxis	❒ 2-pack ❒ __________	❒ 0 ❒ _____
❒ 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.