CenterWell Specialty Pharmacy

E-prescribe: NCPDP ID number 3677955
Fax: 800-345-8534
Phone: 855-264-0104
Monday – Friday, 8 a.m. – 11 p.m., and
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Alpha-1 Prescription Request

Date: _____

Patient information

Patient name: _____
Patient address: _____
_____
Patient phone number: _____
Member ID: _____
Patient date of birth: _____
Allergies: ❑ No known allergies: _____
_____

Current weight: _____❑ lbs ❑ kg

Primary diagnosis:
❑ Alpha-1 antitrypsin deficiency (ICD-10 code): E8801
Secondary diagnosis:
❑ Other ICD-10 code: _____

Clinical history

Serum AAT level: _____ mg/dL OR_____pM
Date tested: _____
PFT FEV % pred.: _____ Date: _____
O2 therapy: _____ L/min
CXR/CT results: _____ Date: _____
Phenotype: ❑ PiZZ ❑ PiSZ ❑ PiMZ ❑ Other: _____
Smoking history: ❑ Yes ❑ No If yes, date stopped: _____
Previous augmentation therapy: ❑ Yes ❑ No
If yes, which one: ❑ Aralast® NP ❑ Prolastin®-C ❑ Glassia®
❑ Zemaira®
Associated medical conditions: ❑ Diabetes ❑ Liver disease
❑ Renal disease ❑ IgA deficiency or antibodies

Clinical documents (please attach)
History and physical (H and P) and progress notes within past six months
Note: H and P to include documented infection history/treatment.

Prescriber signature: _____
Prescriber name: _____
Prescriber address: _____
_____
DEA number: _____
NPI number: _____
Prescriber phone number: _____
Prescriber fax number: _____

*Note: If all information is not completed, the patient request will not be processed. We will contact your office for clarification.

You can send this prescription electronically by selecting "CenterWell Specialty Pharmacy" (National Council for Prescription Drug Programs [NCPDP] ID number 3677955) from the list of pharmacies on your e-prescribing tool.

Prescription information

❑ **Aralast NP** ❑ **Glassia** ❑ **Zemaira**

Dosage: ❑ 60 mg per kg (+/- 10%) IV weekly

❑ Other regimen: _____

Quantity: 28-day supply **Refill** for one year or _____

Pharmacy to dispense ancillary supplies as needed to establish IV and administer drug, including coordination of home health nursing unless otherwise noted. Please strike-through items that are not required:
Normal saline 10 mL IV flush syringe **Directions**: Use as directed to flush line with 10 mL before and after alpha-1 administration and P.R.N. line care.
heparin 100 units/mL 5 mL prefilled syringe (central line patients)
Directions: Use as directed to flush line with 5 mL after final saline flush and P.R.N. line care.

Premedications (Please strike-through items that are not required.):
diphenhydramine 25 mg capsules **Quantity:** 10 **Refill** for one year or ____
Directions: Take one to two capsules PO 30–60 minutes prior to infusion and every four to six hours P.R.N. Maximum four doses per day.
acetaminophen 325 mg tablets **Quantity:** 10 **Refill** for one year or _____
Directions: Take one to two tablets PO 30–60 minutes prior to infusion and every four to six hours P.R.N. Maximum four doses per day.

Other premedications:_____

Anaphylaxis kit maintained in the patient's home:
diphenhydramine 50 mg/mL vial **Quantity**: One **Refills**: 0
Directions: Use as directed via slow IV push as needed for anaphylaxis.
diphenhydramine 25 mg capsules **Quantity:** 10 **Refills**: 0
Directions: Take 25–50 mg PO as needed for anaphylaxis.
epinephrine 0.3 mg two-pack **Quantity**: Two-pack **Refills**: 0
Directions: Use as directed IM as needed for anaphylaxis.

❑ *lidocaine/prilocaine cream 2.5%-2.5%:* **Quantity:** 30 grams
Refill for one year or _____ **Directions***:* Apply topically to needle insertion site 30–60 minutes prior to needle insertion.

Skilled home infusion 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. Visit frequency is based on prescribed dosage orders.

Venous access: ❑ Peripheral ❑ Port ❑ PICC→ number of lumens:
_____
❑ Gravity as tolerated by patient ❑ Other: _____

Has prescriber initiated prior authorization? ❑ Yes ❑ No

First dose? ❑ Yes ❑ No

Expected date of first/next infusion: _____

Site of care: ❑ Patient's home ❑ Physician's office
❑ Outpatient infusion clinic: _____