Alpha$_1$ Proteinase Inhibitor Deficiency Enrollment Form
(Aralast, Glassia)

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

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) Alpha$_1$-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
Site of Care: ☐ MD Office ☐ Infusion Clinic / Outpatient Health ☐ Home Health

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aralast	☐ 60 mg/kg X _____ Kg (pt weight)= Total Dose _____ Mg once every week ☐ Other _____mg/kg x _____kg (pt weight) = Total Dose _____mg every ___ week ***Acceptable allotment +/- 10% based on vial lot/batch**	Quantity: ☐ 4-week supply ☐ 12-week supply Refills: ☐ 1 year ☐ Other: _____
☐ Glassia	☐ 60 mg/kg X _____ Kg (pt weight)= Total Dose _____ Mg once every week ☐ Other _____mg/kg x _____kg (pt weight) = Total Dose _____mg every ___ week ***Acceptable allotment +/- 10% based on vial lot/batch**	Quantity: ☐ 4-week supply ☐ 12-week supply Refills: ☐ 1 year ☐ 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.

Alpha$_1$ Proteinase Inhibitor Deficiency Enrollment Form

(Zemaira)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Zemaira	☐ 60 mg/kg X _____ Kg (pt weight)= Total Dose _____ Mg once every week ☐ Other _____mg/kg x _____kg (pt weight) = Total Dose _____mg every ___ week ***Acceptable allotment +/- 10% based on vial lot/batch**	Quantity: ☐ 4-week supply ☐ 12-week supply Refills: ☐ 1 year ☐ Other: _____

MEDICATION/ SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY / REFILLS
Catheter ☐ PIV ☐ PORT ☐ CVC/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) CVC/PICC: NS 10 mL & ☐ Heparin 10 units/mL or ☐ 100 units/mL 3-5 mL. PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5mL.	Quantity: _____ Refills: _____
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ 1:1000, 0.3mg/0.3 mL (greater than 30 kg/66 lbs) ☐ 1:1000, 0.15mg/0.3 mL (15-30 kg/33-66 lbs) ☐ 1:1000, 0.1 mg/kg, Max 0.3mg (under 15kg) Mild-Moderate Reactions. May repeat in 3-5 minutes as needed for severe allergic reaction, also call 911	Quantity: _____ Refills: _____
☐ Diphenhydramine Oral	PO	☐ 12.25 mg/kg (0-30kg) ☐ 25 mg ☐ 50 mg (Over 30 kg) PRN severe allergic reaction – Call 911	Quantity: _____ Refills: _____
☐ Diphenhydramine 50mg/mL vial	☐ Slow IV ☐ IM	☐ 1 mg/kg (under 15 kg) ☐ 12.5-50 mg (15-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg) PRN severe allergic reaction – Call 911	Quantity: _____ Refills: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____

☐ 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: _____**

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