Alpha1 Proteinase Inhibitor Deficiency Enrollment Form

(Aralast, Glassia)



Fax Referral To: 1-866-843-3221Phone: 1-866-899-1661Email Referral To: DL-NCCNEWREFERRAL@coramhc.com



| | JEMIA LIUN (Complete c | r include demographic she | oot) | |
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| ationt Nama | | | | Gender: 🗌 Male 🛛 Female |
| ddress: | | | ty, State, ZIP Code: | |
| | ethods: Phone (to prime | | | low) 🗌 Email (to email provided below) |
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| | | | | re. Standard data rates apply. Message |
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| NSURANCE IN | FORMATION Please fax | copy of prescription and | insurance cards with th | is form, if available (front and back) |
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| eds by Date: | | Ship to: 🗌 Patient | 🗌 Office 🗌 Other: | |
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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.

Alpha1 Proteinase Inhibitor Deficiency Enrollment Form

(Zemaira)

| | Please Com | plete Patient and Prescriber Information | |
|--|------------|--|--|
|--|------------|--|--|

Patient Name: ___

5

Prescriber Name: ____

PRESCRIPTION INFORMATION

_ Patient DOB: _ Prescriber Phone:

_ Patient Phone: ___

MEDICATION **DOSE & DIRECTIONS QUANTITY/REFILLS** 🗌 60 mg/kg X _____ Kg (pt weight)= Total Dose _____ Mg once every week Zemaira Other ____mg/

| mg/kg x | kg (pt weight) = Total Dose | mg every wee | k | | |
|---|-----------------------------|--------------|---|--|--|
| *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 | 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 | РО | 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 | 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

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

| "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute | | May Substitute / Product Selection Permitted / Substitution Permissible | |
|---|--|--|--|
| Prescriber's Signature: | Date: | Prescriber's Signature: | Date: |
| CA, MA, NC & PR: Interchange is mandated unless Prescribe | er writes the words " No Substitution " | ATTN: New York and Iowa provide | ers, 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 sub mit 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.

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