

Alpha₁ Proteinase Inhibitor Deficiency Enrollment Form

(Aralast, Glassia, Zemaira)



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

NCPDP: 4026325

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)

Is the Patient Insured? Yes No Is the Patient enrolled or eligible for Medicare/Medicaid? Yes No
Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____
 Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: Patient Office Other: _____

Diagnosis (ICD-10):

E88.01 (Congenital Emphysema) Alpha₁-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
<input type="checkbox"/> Aralast <input type="checkbox"/> Glassia <input type="checkbox"/> Zemaira	<input type="checkbox"/> 60 mg/kg X _____ Kg (pt weight) = Total Dose _____ Mg once every week <input type="checkbox"/> Other _____ mg/kg x _____ kg (pt weight) = Total Dose _____ mg every _____ week *Acceptable allotment +/- 10% based on vial lot/batch	Quantity: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> 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.

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
 Patient Address: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION/ SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY / REFILLS
Catheter <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> 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 & <input type="checkbox"/> Heparin 10 units/mL or <input type="checkbox"/> 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: _____
<input type="checkbox"/> Epinephrine **nursing requires**	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> 1:1000, 0.3mg/0.3 mL (greater than 30 kg/66 lbs) <input type="checkbox"/> 1:1000, 0.15mg/0.3 mL (15-30 kg/33-66 lbs) <input type="checkbox"/> 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: _____
<input type="checkbox"/> Diphenhydramine Oral	PO	<input type="checkbox"/> 12.25 mg/kg (0-30kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg) PRN severe allergic reaction – Call 911	Quantity: _____ Refills: _____
<input type="checkbox"/> Diphenhydramine 50mg/mL vial	<input type="checkbox"/> Slow IV <input type="checkbox"/> IM	<input type="checkbox"/> 1 mg/kg (under 15 kg) <input type="checkbox"/> 12.5-50 mg (15-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 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: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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