Alpha₁ Proteinase Inhibitor Deficiency Enrollment Form

(Aralast, Glassia)



Fax Referral To: 1-877-232-5455 Phone: 1-808-254-2727 Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813 NCPDP: 1203417

		Six Simple Steps to Subi	mitting a Referral		
PATIENT INF	ORMATION (Complete	or include demographic shee	et)		
Patient Name:			DOB:	Gender: \square Male	☐ Female
Address:		Cit			
Note: Carrier charge emails and/or text n	es may apply. By providing nessages from CVS Specia	nary # provided below)	ail address above, you an), account, and health cai	e consenting to receiv re. Standard data rates	e automated calls,
		Alte Last Four of S	ernate Phone:		
		Last Four of S , First): R			
2 PRESCRIBER I	NFORMATION				
NDI #	DEA #:	Group or H	State Licerise # locpital:		
Phone:		Cit Contact Person:	y, State, ZIP Code	Contact's Phone:	
Priorie.	гах	Contact Person		contact's Phone	
_	NFORMATION Please for the control of	ax copy of prescription and	insurance cards with th	is form, if available (f	ront and back)
Needs by Date:		Ship to: 🗌 Patient	Office Other:		
Diagnosis (ICD-10		· —			
☐ E88.01 (Conger	nital Emphysema) Alpha ₁ -	Antitrypsin Deficiency	Other Code:	Description	
Patient Clinical In		,, , , , , , , , , , , , , , , , , , ,			
Allergies:		Weight: lb/kg Hei	ght: in/cm Pheno	type:	
Allergies: =EV1 % p	oredicted	Weight:lb/kg Hei Serum A1AT levels (pretreat	ght:in/cm Pheno ma/dL c	type: or microM	
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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)

escriber Name: PRESCRIPTION			Patient Ph			
PRESCRIPTI		P	rescriber Phone:			
	ON INFORMATION					
MEDICATION		DOSE & DIRECTION	DOSE & DIRECTIONS		QUANTITY/REFILLS	
	60 mg/kg X Kg (pt weight)= Total Dose Mg once every week			Quantity: 4-week supply		
Zemaira	Othermg/kg xkg (pt weight) = Total Dosemg every week				12-week supply	
	*Acceptable allotment +/- 10% based on vial lot/batch			Refills:	1 year	
	·				Other:	
MEDICATION/ SUPPLIES	ROUTE	DOSE/	STRENGTH/DIRECTIONS		QUANTITY / REFILLS	
SUPPLIES		Catheter Care/Flush - Or	nly on drug admin days – SASH or	PRN to	KEFIELS	
		maintain IV access and pa			Quantity:	
atheter			units/mL 3-5 mL if multiple days)	Refills:	
PIV PORT	IV		CVC/PICC: NS 10 mL & Heparin 10 units/mL or 100 units/mL			
CVC/PICC		3-5 mL.				
		PORT: 10 mL sterile saline	e to access PORT w/ huber needle	e		
		NS 10 mL & Hepar	NS 10 mL & Heparin 100 units/mL 3-5mL.			
			1:1000, 0.3mg/0.3 mL (greater than 30 kg/66 lbs)			
1		1:1000, 0.15mg/0.3 mL (15-30 kg/33-66 lbs)			Quantity:	
Epinephrine	IM	1:1000, 0.1 mg/kg, Max 0.3mg (under 15kg)			Refills:	
nursing requires'	**	Mild-Moderate Reactions. May repeat in 3-5 minutes as needed				
		for severe allergic reaction, also call 911 12.25 mg/kg (0-30kg)			Quantity:	
] Diphenhydrami	ine PO	25 mg 50 mg (Over 30 kg)			Refills:	
Oral		PRN severe allergic reaction – Call 911				
<u> </u>		1 mg/kg (under 15 kg				
	_	12.5-50 mg (15-30 kg)			Quantity:	
] Diphenhydrami		25 mg 50 mg (Over 30 kg)			Refills:	
Omg/mL vial	☐ IM	May repeat in 3-5 minutes as needed (Max dose-50 mg)				
		PRN severe allergic reaction – Call 911				
	Other:	Other:	cuon – Cau 911		Quantity:	
Othor:	□ Otilei.	U Otilei.				
Other:		Othor			Refills:	
Other:	Other:	Other:			Quantity: Refills:	

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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