Alpha1 Proteinase Inhibitor Deficiency Enrollment Form

(Aralast, Glassia)



 Fax Referral To: 1-855-297-1270
 Phone: 1-888-280-1190

 Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927
 NCPDP: 4026325

Providing the phone number(s) a /S Specialty® about your prescrip via text or email, Specialty Pharr Last Fo ame (Last, First):	DOB: City, State, ZIP Code: Description (s), account, and health car macy will attempt to contact by / Alternate Phone: ur of SSN:Primary L State License #: p or Hospital: City, State, ZIP Code: con:City, State, ZIP Code: on:City, State, ZIP Code: on:City, State, ZIP Code: on:City, State, ZIP Code: con:City, State, ZIP Code: on:City, State, ZIP Code:	bw) Email (to email provided below) e consenting to receive automated calls, e. Standard data rates apply. Message phone. anguage:
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ordinate home health infusion	ose Given: nurse visit necessary 🗌 Yes	_ Next Dose Due:
	CTIONS	QUANTITY/REFILLS
		Quantity: 4-week supply
		12-week supply
		Refills:
		Other:
Kg (pt weight)= Total Dose	e Mg once every week	Quantity: 4-week supply
		☐ 12-week supply
*Acceptable allotment +/- 10%	based on vial lot/batch	Refills: 1 year
STAMP SIGNATURE NOT ALL	OWED Ancillary supplies a	and kits provided as needed for administration
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Date:		e: Date:
	Last De pordinate home health infusion usion Clinic / Outpatient Health DOSE& DIREC (Kg (pt weight)= Total Dose _mg/kg xkg (pt weight) = Total *Acceptable allotment +/- 10% (Kg (pt weight)= Total Dose _mg/kg xkg (pt weight)= Total Dose kg (pt weigh	Last Dose Given: bordinate home health infusion nurse visit necessaryYes usion Clinic / Outpatient HealthHome Health DOSE& DIRECTIONS CKg (pt weight) = Total DoseMg once every week _mg/kg xkg (pt weight) = Total DoseMg once every week *Acceptable allotment +/- 10% based on vial lot/batch CKg (pt weight) = Total DoseMg once every week _mg/kg xkg (pt weight) = Total DoseMg once every week _mg/kg xkg (pt weight) = Total DoseMg once every week *Acceptable allotment +/- 10% based on vial lot/batch s STAMP SIGNATURE NOT ALLOWED Ancillary supplies EREQUIRED (STAMP SIGNATURE NOT ALLOWED xessary / Do Not Substitute / No Substitution / May Substitute / Product Sele Substitution Permissible

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	
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Patient Name: ___

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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 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 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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