Alpha-1 Order Form

Fax completed form to:





PATIENT INFORMATION								
Patient Name:		Date of Birth:			Referral Date:			
Address:				City/State/Zip	:			
Home Phone:		Cell Phone:			Work Phone:			
Secondary Contact:		Height:	Weight:		Male F	emale		
Patient Diagnosis & ICD	-10:							
Allergies:								
PROVIDER INFORMATION								
Physician Name:		Lic.#:		DEA #:				
Practice Name:				NPI#:				
Address:				City/State/Zip	:			
Office Contact:	Phone:			Fax:				
Supervisory Physician (if applicable):								
MS CLINICAL DETAILS								
Type of MS: Primary progressive multiple sclerosis (PPMS)OR Relapsing multiple sclerosis (RMS) Ambulation status: Able to ambulate more than 5 meters Able to ambulate without aid or rest for at least 100 meters Relapse details: Two or more relapses within the previous two years One relapse within the previous year PLEASE ATTACH								
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) Alpha-1 antitrypsin levels, FEV1 score, & smoking status Line access documentation/verification if applicable Letter of medical necessity if drug dosing or indication is outside of FDA guidelines								
NURSING & LAB ORDERS								
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mLOR 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders: Lab Date & Frequency:								
PRESCRIPTION ORDERS								
Anaphylaxis Kit: (Check all that apply)	naphylaxis Kit: Epinephrine 0.3mg IM as needed Solu-cortef 250mg-500mg IV infusion as needed Solu-Medrol 60mg - 125mg IV infusion as needed							
Pre-Medications: (Check all that apply)	Acetaminophenmg PO Diphenhydraminemg as need	minutes prior to infusi ed		mg IV infusi V infusion	onminu _minutes prior to	tes prior to infusion infusion	Other	
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary								
PRODUCT		PRESCRIPT	TION INFORMAT	TION			REFILLS	
Is this a first dose?	Yes No If No, when was last dose given	1?	When is patient due for next	dose?				
ARALAST	60mg/kg IV infusion via gravity OR *Administer at a rate not to exceed 0.2 mL/kg	,	proximately 15 minutes Acceptable allotment +/- 109	% based on vial l	ot/batch			
GLASSIA	60mg/kg IV infusion via gravity OR *Administer at a rate not to exceed 0.2 mL/kg		proximately 15 minutes Acceptable allotment +/- 109	% based on vial l	ot/batch			
OTHER							NONE	
By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.								
		·						
Prescriber's Signature Dispense as Written	Print Name	Date	Prescriber's Signa Substitution Perr		Print Na	ame [Date	





