MRN:_____

DOB:_____

Standard Plan of Treatment for Alpha-1-Antitrypsin Deficiency Therapy

NOTE: *We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.*

1. Patient Name:_____ Height (inches):_____ Weight (lbs):_____

2. Allergies: _____

3. Primary Diagnosis: **E88.01 Alpha-1-antitrypsin deficiency**

Secondary ICD-10 Code:_____ Diagnosis description: _____

4. Orders:

☐ Glassia®_____ mg/kg (+/- 10%) IV over ____ minutes via pump with filter as directed

☐ Prolastin-C®_____ mg/kg (+/- 10%) IV over_____ minutes via pump with filter as directed

☐ Aralast NP™_____ mg/kg (+/- 10%) IV over_____ minutes via pump with filter as directed

5. Frequency: Orders to be completed every ☐ 1 Week ☐ other:_____

If vials cannot fit within 10% will round up to the nearest vial.

Special Orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

6. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

MRN:_____

DOB:_____

Guidelines for Prescribing Alpha-1-Antitrypsin Deficiency Therapy

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

☐ Include signed and completed **Plan of Treatment**.

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis such as Alpha-1 antitrypsin (AAT) protein blood testing, genetic testing results, Pulmonary Function Tests, and/or CT scanning.**

☐ Other as requested: _____

_____

Pre-Screening:

☐ **IgA level (Therapy is contraindicated in individuals with selective IgA deficiencies who have a known antibody against IgA, since they may experience severe reactions)**

** Warnings/Precautions: Adverse Events to Alpha 1-Proteinase Inhibitor augmentation therapy: Before beginning therapy, a patient should be tested for IgA deficiency, a hereditary condition that makes potentially severe allergic reactions to plasma products more likely. Therapy is contraindicated in individuals with selective IgA deficiencies who have a known antibody against IgA, since they may experience severe reactions, including anaphylaxis. Product is derived from human plasma, it may carry a risk of transmitting infectious agents, e.g., viruses and theoretically, the Creutzfeldt-Jakob disease (CJD) agent. It is suggested that immunization against both Hepatitis A and B be considered for all Alphas to reduce the risk of liver injury. Therapy can be started independent of whether or when hepatitis vaccine will be given. Pregnancy/Breastfeeding: Discussion and risk evaluation should be discussed prior to start of therapy. See full prescribing information.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.