

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

## Alpha-1-Antitrypsin Deficiency Standard Plan of Treatment

### PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
<input type="checkbox"/> See list	<input type="checkbox"/> NDKA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

E88.01 - Alpha-1-Antitrypsin Deficiency	J43.8 - Other Emphysema
J43.2 - Panlobular Emphysema	J43.1 - Centrilobular Emphysema
<input type="checkbox"/> - Other:	

### REQUESTED DOCUMENTATION:

### PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5	Alpha-1 Anti-trypsin (AAT) blood testing	THERAPY:	
6			
			<b>Continue current order until insurance approved</b>

### MEDICATION ORDERS:

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.

### MEDICATION/DOSE:

Glassia® 60mg/kg (+/- 10%) IV over at least 15 - 30 minutes via pump with filter as directed  
 Other dose: \_\_\_\_\_

Prolastin-C® 60mg/kg (+/- 10%) IV over at least 15 - 30 minutes via pump with filter as directed  
 Other dose: \_\_\_\_\_

Aralast NP™ 60mg/kg (+/- 10%) IV over at least 15 - 30 minutes via pump with filter as directed  
 Other dose: \_\_\_\_\_

If vial size is not within 10% of the patients dose, the dose will be rounded up to the nearest whole vial size

### FREQUENCY:

Every 1 week.  
 Other: \_\_\_\_\_

### SPECIAL/LAB ORDERS:

\_\_\_\_\_



Refills x 12 months unless noted otherwise here:

### LINE USE/CARE ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure

### ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.



### PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

### PRESCRIBER SIGNATURE: (No stamp signatures)

DATE

Dispense as written/Brand medically necessary	Substitution permitted



## Checklist for referrals to AccuRX Infusion:

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**

Palmetto Infusion 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. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

[www.AccuRXInfusion.com](http://www.AccuRXInfusion.com)